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STUDY  
PROJECT

MEDICAL CIVIC ACTION PROGRAMS (MEDCAPS)  
AND MEDICAL READINESS TRAINING EXERCISES  
(MEDRETES) AS INSTRUMENTS OF FOREIGN POLICY

BY

COLONEL ELRAY JENKINS, MC

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nation caught in conflict and with inadequate medical resources. Following the end of the Vietnam War, the Medical Corps' involvement in humanitarian and civic action programs declined. In response to low intensity conflicts in Central America, the U.S. Army Medical Corps restarted MEDCAPS in Honduras. These programs were later renamed Medical Readiness Training Exercises (MEDRETES). Low intensity conflict (LIC), including insurgencies and counter-insurgencies, is the major warfare we face today. The medical corps must be prepared to deal with LIC. This study reviews MEDCAPS and MEDRETES as conducted in Honduras and makes recommendations for their success. It is my thesis that humanitarian and civic action programs can play a very important role in countering insurgencies and in nation building. U.S. assistance in the form of MEDCAPS/ MEDRETES is a very powerful policy tool, if conducted properly. If not conducted properly, they will be counterproductive to U.S. foreign policy objectives and to our national security interests. It is also my thesis that the Medical Corps has the expertise and skill to run such programs. Although numerous factors and issues, such as Congressional concerns, budgetary problems, and interagency relations complicate the question, the problems are not insurmountable. This study discusses the factors bearing on civic action programs, steps for success, and concludes with recommendations for future programs.

## **USAWC MILITARY STUDIES PROGRAM PAPER**

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### **MEDICAL CIVIC ACTION PROGRAMS (MEDCAPS) AND MEDICAL READINESS TRAINING EXERCISES (MEDRETES) AS INSTRUMENTS OF FOREIGN POLICY**

by

**Colonel ElRay Jenkins, MC**

**Colonel Alden M. Cunningham, FA  
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**US Army War College  
Carlisle Barracks, Pennsylvania 17013  
24 May 1988**

## ABSTRACT

**AUTHOR:** ElRay Jenkins, COL, MC

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The Medical Corps has conducted humanitarian and civic action programs since the 1960's. During the Vietnam war the U.S. Army Medical Corps ran Medical Civic Programs (MEDCAPS), initially for the Vietnamese military and later for Vietnamese civilians. The primary objective was to win the "hearts and minds" of the people. Other objectives were to increase the popularity of the Vietnamese and U.S. military forces, assist in the development of the Vietnamese medical infrastructure, and provide humanitarian assistance to a beleaguered nation caught in conflict and with inadequate medical resources. Following the end of the Vietnam war, the Medical Corps' involvement in humanitarian and civic action programs declined. In response to low intensity conflicts in Central America, the U.S. Army Medical Corps restarted MEDCAPS in Honduras. These programs were later renamed Medical Readiness Training Exercises (MEDRETES). Low intensity conflict (LIC), including insurgencies and counter-insurgencies, is the major warfare we face today. The medical corps must be prepared to deal with LIC. This study reviews MEDCAPS and MEDRETES as conducted in Honduras and makes recommendations for their success. It is my thesis that humanitarian and civic action programs can play a very important role in countering insurgencies and in nation building. U.S. assistance in the form of MEDCAPS/MEDRETES is a very powerful policy tool, if conducted properly. If not conducted properly, they will be counterproductive to U.S. foreign policy objectives and to our national security interests. It is also my thesis that the Medical Corps has the expertise and skill to run such programs. Although numerous factors and issues, such as Congressional concerns, budgetary problems, and interagency relations complicate the question, the problems are not insurmountable. This study discusses the factors bearing on civic action programs, steps for success, and concludes with recommendations for future programs. ←

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## **Chapter I**

### **Introduction**

Low Intensity Conflict (LIC) has been recognized as a serious threat to our U.S. national interests and the achievement of important U.S. objectives. As described in the 1988 White House Paper, National Security Strategy of the United States, low intensity conflicts threatens international peace and the internal stability of friendly states and challenges hope for human betterment.<sup>1</sup> President Reagan further clarifies US strategy in dealing with LIC as:<sup>2</sup>

"Consistent with our strategies for dealing with low intensity conflict, when it is in the U.S. interest to do so, the United States will:

1. Work to ameliorate the underlying causes of conflict in the Third World by promoting economic development and the growth of democratic political institutions.
2. Take measures to strengthen friendly nations facing internal or external threats to their independence and stability by employing appropriate instruments of U.S. power. Where possible, action will be taken early -- before instability leads to widespread violence; and emphasis will be placed on those measures which strengthen the threatened regime's long-term capability to deal with threats to its freedom and stability."

President Reagan has clearly expressed our national commitment to combating low intensity conflict in developing countries. The responsibility now falls upon the Department of State and the Department of Defense to develop plans and doctrine for meeting this requirement. In doing so, each must recognize that by definition low intensity conflicts occur below levels of conventional war, sometimes described as "war in the shadows", and often involve protracted struggles between

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<sup>1</sup>National Security Strategy of the United States, The White House, Washington D.C., Jan. 1988, p. 6.

<sup>2</sup>Ibid, p. 34.

competing ideologies and principles in third world countries.<sup>3</sup> As stated above, this new type of warfare can be waged by using social-political-economic power, rather than the traditional use of military force. However, military force is not ruled out. Such actions include humanitarian and civic action programs, for which the Army Medical Department (AMEDD) is well suited and has much experience.

The AMEDD has one of the finest educational systems in the world. It is superb at training hospital administrators, physicians, critical care nurses, bio-medical technicians, health systems managers, combat medics, and other skills. It is well known for its organizational ability. It knows how to establish military health care organizations and organize efficient medical logistical procurement and distribution systems. The AMEDD also runs prestigious research and development laboratories. However, while it has recognized for years that it can play a significant part in furthering U.S. policies abroad, this new thrust of direct involvement in low intensity conflict catches it at a time when little AMEDD LIC doctrine has been developed. The current resource-requirement mismatch regarding peacetime medical care complicates this situation and takes attention away from doctrinal concerns.

Low intensity conflict (LIC), including insurgencies and counter-insurgencies, is the major warfare we face today. The medical corps must be prepared to deal with LIC. This study reviews MEDCAPS and MEDRETES as conducted in Honduras and makes recommendations for their success. It is my thesis that humanitarian and civic action programs can play a very important role in countering insurgencies and in nation building. U.S. assistance in the form of MEDCAPS/MEDRETES is a very powerful policy tool, if conducted properly. If not conducted properly, they will be

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<sup>3</sup>Ibid, p. 34; Thornton, William H. Army Medical Department Roles and Functions in Low Intensity Conflict, Army-Air Force Center for Low Intensity Conflict, Langley Air Force Base, VA, August 1987, p. 2.



counterproductive to U.S. foreign policy objectives and to our national security interests. It is also my thesis that the Medical Corps has the expertise and skill to run such programs. Although numerous factors and issues, such as Congressional concerns, budgetary problems, and interagency relations complicate the question, the problems are not insurmountable. This study discusses the factors bearing on civic action programs, steps for success, and concludes with recommendations for future programs.

### The Problem.

The Army Medical department, for all of its Vietnamese experience in civic action and humanitarian assistance program, has experienced difficulty in developing doctrine for low intensity conflicts. Even Army Regulations are relatively silent or general in nature on this topic. Army Field Manual FM 100-20, Low Intensity Conflict, only discusses medical civic action programs in general terms.<sup>4</sup> This is not inconsistent with the problems the Army as a whole has experienced in recognizing LIC as a credible mission today. The AirLand Battle Concepts, Army of Excellence initiatives, and force modernization programs have all focused on the mid and high intensity end of the conflict spectrum.<sup>5</sup> During the 1980s we have witnessed several initiatives that have recognized the less visible, but equally important low intensity conflict end of the spectrum. Increased emphasis on Special Operations Forces, the creation of the Light Infantry Divisions, and the Central American conflicts have all underscored the importance of LIC doctrine.<sup>6</sup> The most significant decision impacting on doctrine was the formation of

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<sup>4</sup>US Department of the Army, Field Manual 100-20, Low Intensity Conflict, Washington D.C., January 1981, p. 132.

<sup>5</sup>Morelli, Donald R., Ferguson, Michael M. Airland Battle and Low Intensity Warfare, Training and Doctrine Command, Ft. Monroe, VA, 12 January 1984, pp. 1-4.

<sup>6</sup>Ibid, p. 4

the Joint Army/Air Force Center for Low Intensity Conflict (CLIC) in 1986. Their charter specifically states:<sup>7</sup>

"The CLIC will serve as the Army/Air Force focal point for matters relating to military operations in low intensity conflict and civil-military activities related thereto."

The charter tasks CLIC to develop joint operations concepts, conduct operational analyses, identify capability shortfalls, propose initiatives, and develop and propose policy initiatives.<sup>8</sup> In addition, CLIC is required to coordinate its activities with all MACOM/MAJCOM's.

There are several unique LIC medical missions that when applied properly may help eliminate the root causes of insurgency. Generally, these missions have been carried out by Army Special Operations Forces (SOF) or the 18th Airborne Corps.<sup>9</sup> Support for peacekeeping operations, peacetime contingency operations, and combatting terrorism are well understood and properly supported. It is in the role of insurgency/counterinsurgency or LIC operations that new doctrine is slowly emerging that wrestles with such questions as "nation building," "economic development," "civic action" and "humanitarian assistance." These all carry socio-economic-political overtones that creates a new role for the AMEDD. Since these are the root causes of insurgencies, it logically follows that programs need to be developed that will in the long run prevent actual deployment of combat forces to save a nation. Thus, the AMEDD is now thrust in a "preventive" role and is

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<sup>7</sup>Activation Plan, Army/Air Force Center for Low Intensity Conflict (CLIC), 29 Jan. 1986, Headquarters, Department of the Army, DCS/Operations and Plans and Headquarters, US Air Force, DCS/Plans and Operations, Washington, D.C., p. A-1.

<sup>8</sup>Ibid, pp. A2-A4.

<sup>9</sup>Op cit, Thornton, p. 3.

experiencing some difficulty in dealing with it. The new objective is not to win battles, but to assist a developing country in gaining enough time to solve their internal problems and implement reforms.<sup>10</sup>

Civic action programs for the AMEDD are not new. They have been conducted around the world by the medical departments of the US military services since the early 1960s. However, the formation of the Agency for International Development (AID) in 1961 shifted the responsibility for administering the development of health care delivery systems in lesser developed nations to the State Department.<sup>11</sup> Since that time there has been a decreased emphasis on military service involvement in assisting the development of medical delivery systems in foreign countries.<sup>12</sup>

This lack of attention may be slowly changing as the Academy of Health Sciences (AHS) is now addressing the doctrinal issue of LIC operations and has directed the development of doctrine to meet this requirement. Field Manual, 8-999a, "Health Service Support in Low Intensity conflict" has been published in draft form and distributed for review/comment.<sup>13</sup> While not yet approved as DA doctrine yet, it does outline important doctrinal issues addressing for the first time the important role the Army Medical Department plays in peacekeeping operations, terrorism counteraction, foreign internal defense, low intensity conflict, humanitarian assistance, and peacetime contingency operations. This is a positive step in the right direction.

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<sup>10</sup>CLIC Papers, Operational Considerations for Military Involvement in Low Intensity Conflict, Army-Air Force Center for Low Intensity Conflict, Langley AFB, VA, June, 1987, p. 10.

<sup>11</sup>U.S. Congress, Report of the Senate Committee on Foreign Relations, The Foreign Assistance Act of 1961, U.S. Government Printing Office, Washington, D.C., 1961, p. 4.

<sup>12</sup>Hendley, James Williamson, Health Services as an Instrument of United States Foreign Policy Toward the Lesser Developed Nations, University of Iowa, Ann Arbor, University Microfilm, 1971, p. 384-386.

<sup>13</sup>Health Service Support in Low Intensity Conflict, Coordinating Draft, FM 8-999A, Academy of Health Sciences, November 1987.

Despite decreased emphasis on AMEDD involvement in humanitarian and civic action programs since Vietnam, there are several AMEDD programs tailored for LIC doctrine. Each has been used at one time or another to further national interests. The first program involves use of Special Forces medical personnel. While the Special Forces have a highly skilled field medical force, they lack the depth and experience to tackle complex problems. Generally, Special Forces are limited to operating on the primary level of the health care system. They provide direct health care to patients and train military personnel, rather than train indigenous civilian personnel in health care skills.<sup>14</sup>

Second, there are Mobile Training Teams (MTTs). Historically these missions have been ad hoc groups composed of personnel selected for their expertise in specific regions of the world.<sup>15</sup> Depending upon the problem, these teams are sent for specific periods of time for narrowly defined missions and composed of individuals from Special Forces units or from within the Army Medical Department. These teams generally work directly under the control of the in-country Security Assistance Organization (SAO).<sup>16</sup> Unfortunately, the Army lacks specific doctrine for the use and conduct of medical mobile training teams.

Medical Civil Action Programs (MEDCAPS), and Medical Readiness Training Exercises (MEDRETES) make up the only other programs.<sup>17</sup> These two programs are basically very similar in nature. This study intends to evaluate the AMEDD's capability to respond to the new emphasis on low intensity conflict by a review of MEDCAPS and MEDRETES being conducted in Honduras. This study considers the historical perspectives of these two programs, their implementation, relationship to

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<sup>14</sup>Bruss, Don. The Emerging Role of US Military in Low-Intensity Conflict, Low Intensity Conflict and Modern Technology. 1985. pp. 223-235.

<sup>15</sup>Ibid, p. 230.

<sup>16</sup>Op cit, Thornton, p. 6.

<sup>17</sup>Op cit, Thornton, pp. 6-7.

low intensity conflicts, outcomes, impediments to success, and what can be done to solve these challenges. Honduras represents the only foreign country where MEDCAPS/MEDRETES operate at this time. This study will touch upon health service relationships and humanitarian assistance to developing countries and health conditions in third world countries.

A strong perception exists among senior medical corps officers that the AMEDD can play a significant role in countering insurgency threats through application of medical civic actions. The focus on the following question: are Medical Civic Action Programs and Medical Readiness Training Exercises furthering our national interests and meeting our overall goals of nation building?

In the overall spectrum of assisting developing countries, the AMEDD does have the potential for making significant contributions. This does not imply that the AMEDD can solve all the internal medical problems of a sovereign nation, but only that it has the expertise, resources, and organizational capability to assist legitimate governments resolve their internal dilemmas. By the same token, this also implies selective application because the AMEDD certainly cannot meet the demands of the entire third world. However, medical operations in the the low intensity conflict scenario are seen as the most cost effective and least controversial means of employing US military capabilities in support of U.S. national interests.<sup>18</sup>

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<sup>18</sup>Briefing to General Maxwell Thurman, Vice Chief of Staff, US Army, on "The Medical Role in Low Intensity Conflict" by the Academy of Health Sciences, Feb. 1984; Opening remarks by Major General William P. Winkler to the SPR on military medicine's appropriate role in low intensity conflict, Academy of Health Sciences, Fort Sam Houston, TX, 29 May 1984.

## **Chapter 2**

### **A Historical Perspective of MEDCAPS in Vietnam**

Medical Civic Action Programs (MEDCAPS) are nothing new. During the Vietnam conflict they were used extensively to win the "heart and minds" of the population. Not since the Philippine insurrection had the United States been involved in an unconventional, or guerrilla war. The Vietnam conflict presented unique, complex problems that required new problem solving techniques designed to counter insurgency threats. US staff planners developed four humanitarian assistance programs during the course of that war.<sup>1</sup> These programs provided medical care to Vietnamese civilians and were designed to increase the popularity of Vietnamese and US military forces. We were dealing with an unpopular war and MEDCAPS provided the perfect setting to show the "good" we could do for a people engulfed in conflict.<sup>2</sup>

In order to understand Honduran Medical Readiness Training Exercises (MEDRETES), a brief discussion of the Vietnamese MEDCAPS is necessary. Medical Civic Action Programs are the foundation upon which MEDRETES are built and were developed by US planners using several basic assumptions. First, bored, underutilized highly professional medical personnel must be kept busy. Second, Americans have a basic desire to provide humanitarian assistance to those who are less fortunate. Third, providing humanitarian assistance to indigenous, poverty stricken, disease ridden, unfortunate third world populations caught in the middle

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<sup>1</sup> The four humanitarian programs developed were: Medical Civic Action Program I & II (MEDCAP I, MEDCAP II), Military Provincial Health Assistance Program (MILPHAP), and Civilian War Casualty Program (CWCP). MEDCAP I assisted the Vietnamese armed forces treat civilians, MEDCAP II was for US military medical personnel to treat civilians directly, MILPHAP assisted the Vietnamese government in expanding health services, and CWCP treated Vietnamese civilians injured directly by US military activity.

<sup>2</sup>Bruss, Don. The Emerging Role of US Military in Low-Intensity Conflict, Low Intensity Conflict and Modern Technology, 1983, p. 229.

of low intensity conflicts might be a way to winning them to your side.<sup>3</sup> These are the same assumptions being used in Honduras today.

The MEDCAP I program evolved from an original concept of assisting the Vietnamese military forces to build their medical assets to one of where we were providing all the care. It was recognized early that the success of the war depended primarily upon the use of Vietnamese forces and the support of the Vietnamese people. In 1961, while the conflict was still confined to a low intensity level, civic action programs were initiated at the request of the Chief of the Military Assistance Advisory Group Vietnam (MAAGV). As Greenhut stated, "The objective of the program was to create a bond between the Vietnamese armed forces and government with the rural population. American personnel were to be used only until the Vietnamese proved capable of continuing on their own."<sup>4</sup>

The Department of Defense (DOD) authorized and deployed the first medical team (joint Army, Air Force and Navy personnel) to Vietnam in 1963 for the specific purpose of providing humanitarian assistance. Teams were formed and assigned to Vietnam Army (ARVN) forces with the specific purpose of augmenting the Vietnamese army and treating Vietnamese civilians displaced in encampments and the new "strategic hamlets."<sup>5</sup> The teams trained paramilitary force medical aid personnel, treated civilians in insecure threatened villages where security was provided by Vietnamese forces, and treated when necessary ARVN military and paramilitary personnel and US advisors.<sup>6</sup>

The MEDCAP mode of operation is described by Anderson:

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<sup>3</sup> Greenhut, Jeffrey, Ph.D. Medical Civic Action in Low Intensity Conflict: The Vietnam Experience, paper presented at the 40th Annual Civil Affairs Association Conference, June 4-6, 1967, Capitol Hilton, Washington, D.C., p. 1.

<sup>4</sup> Ibid, p. 3.

<sup>5</sup> Ibid, p. 3-4.

<sup>6</sup> Neel, Spurgeon, COL. The Medical Role in Army Stability Operations, Military Medicine 132(8), August 1967, pp. 606-7.

"Teams....set up in public buildings to treat people summoned by the village chief. A typical visiting group of medical workers consisted of six people of which from one to three were American. Where a village health worker was in residence, team members solicited his advice. Some teams stayed in an area for weeks and went to the same village more than once for follow up care. Of course, in some areas, revisits were difficult, and without revisits, the medical effectiveness of the visits was very limited. For American health workers, this created tension in resolving the conflict between the twin goals of bringing effective medical care to people and the psychological warfare (PSYWAR) aspect of the MEDCAP program."<sup>7</sup>

The MEDCAP's were funded by the Agency for International Development (AID), medical supplies were transferred to the ARVN medical supply system, and all efforts were expanded to identify the program as Vietnamese government sponsored. Pharmaceuticals were dispensed in Vietnamese government marked containers and handouts and posters were distributed to help educate the population in sanitation and first aid.<sup>8</sup>

The overall consensus was that the program was a success. Only after the war did opinions change. Staff planners were elated at the statistics: 914,000 treatments to Vietnamese civilians in 1963; nearly three million treatments in 1964; cost -- only twenty-two cents per treatment.<sup>9</sup> The "hearts and minds" of the Vietnamese people were being won over to the government. Success breeds success. As US force size rapidly expanded in country, every US battalion or larger was encouraged to conduct MEDCAP's with the only stipulation that they coordinate with and receive approval from appropriate local health, government, and MACV officials. MEDCAP II was launched. US Army battalions, brigades, divisions, and

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<sup>7</sup> Anderson, James E. Jr., MC. The Field Experience of a Medical Civic Action Team in South VietNam. Military Medicine 129(11), November 1964, p. 1052.

<sup>8</sup> Op cit, Greenhut, p 6.

<sup>9</sup> MACV Army Medical Service Activity Report (AMSAR), 1964.



field hospitals organized and conducted civic action programs.<sup>10</sup> The teams treated common medical ailments, e.g. dermatitis, parasites, vitamin deficiencies, minor injuries, simple infections, and respiratory complaints, and referred or evacuated serious cases elsewhere. Medics learned Vietnamese. Dentists pulled teeth and Veterinarians treated livestock. Veterinary Civic Action Teams (VETCAP) were organized to treat and vaccinate animals.<sup>11</sup> Statistics ruled the day -- two million outpatient treatments, 143,000 immunizations, and 3,500 Vietnamese civilians trained as hamlet health workers in 1968.<sup>12</sup>

The medical civic actions expanded rapidly up until 1969 when planning for withdrawal of American medical personnel and turnover of their functions to the Vietnamese ensued. MEDCAP activities then declined steadily and were discontinued in 1972 when funding ceased. The war was over and this tremendous medical assistance effort had made little impact on the outcome of the conflict. *While many individuals received medical care for conditions that may have deteriorated without intervention and many Vietnamese medical personnel were trained, determining if the program was effective in achieving its primary objective of winning the "hearts and minds" of the populace has proven to be very difficult. On the surface it would appear that the program didn't work in Vietnam. Actually, it worked quite well. The problem was that Vietnam was not a low intensity conflict after 1964. In order for humanitarian assistance programs to work, they must be directed at the lower end of the LIC spectrum when the government can protect the population.*<sup>13</sup> To win the hearts and minds of the

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<sup>10</sup>Op cit, Greenhut, pp. 7-10.

<sup>11</sup>USARV AMSAR, 1968, p. 104; USARV AMSAR, 1969, pp. 47-8.

<sup>12</sup>Op cit, Greenhut, p. 11

<sup>13</sup>Taylor, James A. A lecture on The Emerging Role of Military Medicine in Low Intensity Conflict, St. Louis University Medical Center, St. Louis, Mo., pp. 1-16.

population, or as Taylor said, "...modify and shape the value systems..."<sup>14</sup>, MEDCAP actions must be implemented before the conflict has expanded into a major confrontation and the guerrillas control large segments of the country.

The young, ambitious health care professionals, usually fresh out of medical training, tackled the Vietnamese health care problems with enthusiasm and dedication. Their efforts were commendable. However, in third world countries with serious endemic diseases, maldistribution of medical manpower and resources, permanent change requires long-term commitment. Malnourishment, malaria and poor sanitation is not cured by an occasional MEDCAP visit. Regardless of the Vietnam outcome, most of our present-day concepts on utilization of medical forces in LIC can be traced directly to this conflict.

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<sup>14</sup>Ibid, page 14.

## **Chapter 3**

### **A HISTORICAL PERSPECTIVE OF MEDCAPS IN HONDURAS**

The United States has maintained warm cordial relations with Honduras since World War II. In 1954 a military assistance pact was signed which provided for stationing of US military advisers in Honduras, training Honduran military personnel, and providing military equipment. In 1981, in order to counter the spread of insurgent activities in Central America, U.S. Security Assistance Programs were expanded. In response to the significant build-up and threat of the Nicaraguan military forces and Salvadoran guerrilla forces, Honduras is now embarked on a force modernization program seeking to develop a highly mobile deterrent force. At the request of the Honduran government, Mobile Training Teams (MTT) were dispatched to train Honduran soldiers in small unit tactics, helicopter maintenance and air operations, and to establish the Regional Military Training Center near Trujillo and Puerto Castilla. In addition, Honduran Army enlisted soldiers and officers are being trained at the US Army School of the Americas at Fort Benning, Georgia. In 1982, the US improved two airfields (Palmerola Air Base and La Ceiba) in return for access for various contingency uses including transit, search and rescue, and evacuation.<sup>1</sup>

Conducting joint exercises with the Honduran military has a long history dating back to 1965. Due to the threat from foreign forces, most notably Nicaraguan, US Armed Forces significantly expanded the scope and size of the joint exercises beginning in 1983. The objective of these exercises has been to bolster Honduran

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<sup>1</sup> Welcome to Honduras: A Guide for U.S. Participants in Combined Military Exercises in Honduras, pamphlet produced by Joint Task Force Bravo Public Affairs Office, Palmerola, Honduras, 1985, pp. 3-1 to 3-3.

defenses, demonstrate US resolve and commitment, and improve readiness training. Additional objectives as outlined by Joint Task Force Bravo (JTF-B) are<sup>2</sup>:

1. To practice procedures for command and control of joint operations in coordination with the armed forces of friendly nations in the region.
2. To evaluate U.S. forces' capabilities to conduct combined military operations.
3. To test and practice existing plans for operations in the region.
4. To practice the deployment and sustainment of U.S. forces under austere conditions.
5. To practice the deployment and employment of a Joint Task Force Headquarters in command and control of joint operations.

American military presence in Honduras is divided between permanent party and personnel on temporary duty status. The U.S. Defense Attache Office with six military personnel and the Military Assistance Group of six military and two civilian personnel make up the permanent presence. All other U.S. forces in Honduras are on temporary duty and limited to a maximum of 179 days in country.<sup>3</sup>

The first of several large joint exercises, AHUAS TARA I (BIG PINE I) commenced in early 1983. This was followed on a much larger scale by AHUAS TARA II in August 1983 and included the deployment of the 41st Combat Support Hospital, a clearing company, a ground ambulance company, a preventive medicine detachment, a veterinary detachment, and an air ambulance company.<sup>4</sup> Granadero

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<sup>2</sup> Ibid, pp. 3-5 to 3-7.

<sup>3</sup> Interview with LTC William H. Thornton, USA, Army-Air Force Center for Low Intensity Conflict, Langley Air Force Base, VA, February 13, 1988.

<sup>4</sup> The units deployed were the 41st Combat Support Hospital from Ft. Sam Houston, TX, the 546th Medical Company (CLR) from Ft. Benning, GA, the 690th Medical Company (AMB) from Ft. Benning, GA, D Co, 326th MED BN (AIR AMB) from Ft. Campbell, KY, the 225th Preventive MED Detachment (LC) from St. Sill, OK, and the 73rd Veterinary DET (JA) from Ft. Jackson, SC.

I, a multi-national exercise involving Honduras, El Salvador and the U.S. commenced in 1984 and AHUAS TARA III, a joint U.S./Honduran exercise and continuation of the Big Pine series was conducted in 1985.<sup>5</sup> All of these large joint exercises were for specified time periods with units redeploying upon termination. Additional short-term training such as Deployment Training Exercises (DTEs) and Deployments for Training (DFTs) was initiated in 1984.<sup>6</sup> These are short-term two to four week deployments with the specific objective of training in an austere tropical environment and providing realistic experiences not gained elsewhere.

Following completion of AHUAS TARA II in 1984, a semi-permanent American presence was established at Palmerola Air Base near the city of Comayagua and designated as Joint Task Force Bravo (JTF-B).<sup>7</sup> The mission of JTF-B is specific: coordinate, control, and support U.S. forces in Honduras.

In August 1983, elements of the 41st Combat Support Hospital (CSH) were deployed to support AHUAS TARA II. The primary mission of the CSH was to provide medical support for U.S. forces participating in the exercise. However, the Commander of the 41st CSH envisioned a secondary mission for his staff based upon the same assumptions stated earlier about Vietnam. With the full concurrence of SOUTHCOM and Health Services Command, he initiated a humanitarian assistance MEDCAP program for the Honduran population. Within one week after his advance party had arrived and before his CSH had fully deployed, he and his staff had already commenced with formal meetings in Tegucigalpa to establish MEDCAP's in Honduras.<sup>8</sup>

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<sup>5</sup> Op cit, Welcome to Honduras, p. 3-4.

<sup>6</sup> Ibid, p. 3-6.

<sup>7</sup> Interview with COL Russ Zajchuk, Office of the Surgeon General, Washington, D.C., 4 March 1988. COL Zajchuk was Commander of the 41st Combat Support Hospital, Palmerola Air Base, Honduras, from August, 1983 to February, 1984.

<sup>8</sup> Zajchuk, Russ. AHUAS TARA II Honduras, C.A. After Action Report, 18 February 1984, Section A, p. 1.

The program that Col Zajtchuk developed was completely different from the ongoing effort in El Salvador and very similar to the MEDCAP I and II programs of the Vietnamese era. In El Salvador, The Commander of US MILGRP had requested a U.S. medical survey team in early 1983 to evaluate El Salvador's military medical capability. Based upon the survey findings of high morbidity and mortality among Salvadoran soldiers due to the lack of a military medical system, Mobile Training Teams (medical) have been dispatched every six months since then. Their mission is significant: develop the Salvadoran military medical system from front line combat medical corpsman up through a central military hospital and including evacuation, medical supply, administration, and biomedical repair systems.<sup>9</sup>

USSOUTHCOM had also performed a medical survey of the Honduran military medical system in 1983. A similar recommendation was made -- dispatch MTT's to assist the Honduran military medical system. However, in the meantime, a U.S. combat support hospital was established at Palmerola. This U.S. medical presence, even though it was replaced after six months by the 47th field Hospital, and then scaled down to the Medical Element, JTF-B, was probably the primary reason no MTT was sent. From the very outset, the CSH became extremely active in humanitarian assistance programs and interfacing with the Honduran military medical system, including training Honduran combat medics. In addition, Congressional reluctance to commit additional resources and funds to Central America may have been a reason no MTT was sent.

Immediately upon arrival in Honduras COL Zajtchuk set about organizing several comprehensive programs. He believed that the Humanitarian Assistance Programs had the potential of becoming the greatest promoter of developing a

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<sup>9</sup> Taylor, John F. and Fields, Jerry L. Health Care as an Instrument of Foreign Policy, USA War College Military Studies Program, Army War College, Carlisle Barracks, PA, 9 May 1984.

positive U.S. policy in Central America.<sup>10</sup> His initiatives established the foundation upon which future medical commanders could build.

His goals and objectives were: 1. Provide medical support to American troops on exercise in Honduras 2. Improve unit readiness by providing realistic training in a field setting over an extended period of time. 3. Test medical equipment in a realistic field setting 4. Improve U.S. relations with the Honduran people through the establishment of MEDCAPS. 5. Assist the Honduran military medical system.<sup>11</sup> The only mission for which he had been assigned and funded was the first. He had been given "no" guidance or tasking from The Surgeon Generals Office, SOUTHCOM or Health Services Command reference any other duties.<sup>12</sup> He was there to treat the US troops.

Based upon his own initiative, he embarked upon developing an infrastructure for training his staff in tropical diseases, developing a system for interfacing with the Honduran Ministry of Health and Army medical department, extending humanitarian care to the local populations, providing medical maintenance evaluations/support to Honduran hospitals, and training Honduran combat medics.<sup>13</sup> Some would argue that his overall objective was to keep his highly trained staff gainfully employed, improve morale, and prevent boredom. While these are certainly spin-off benefits, it would appear that his real intention was to take advantage of a unique opportunity and provide US physicians, nurses, administrators, medics and support personnel field training that was unavailable elsewhere.

This was the first time that the 41st CSH had been deployed in the field for an extended period of time, and there were many valuable lessons to be learned.

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<sup>10</sup> Op cit, Zajchuk interview.

<sup>11</sup> Op cit, Zajchuk After Action Report, Section A, pp 1-12.

<sup>12</sup> Op cit, Zajchuk interview.

<sup>13</sup> Ibid, Zajchuk interview.

Based upon our Vietnam experience, military medical personnel eagerly participate in humanitarian efforts when they feel they are accomplishing something worthwhile -- saving lives, treating disease, improving health -- providing a service where positive effects are experienced, felt, and lived. There are no shortage of volunteers for MEDCAPS.

Throughout August and September 1983 formal meetings were held with members of the US Embassy, the Honduras Military, the Honduran Ministry of Health (MOH), the US Military Group-Honduras, SOUTHCOM, USAID and their sub-elements.<sup>14</sup> The valuable lesson learned here involved coordination and cooperation when dealing with a host nation. Honduras initially reacted favorably with some reservations. Both groups discussed problems, not all of which had quick answers. Honduran military could be treated in our hospital, but the treatment of civilian Hondurans needed to be discussed further. USAID was pessimistic about treating civilians. *The Honduran military was concerned about treating civilians -- something they had little experience with.* The first outcome was an agreement with the Honduran Surgeon General on "the desirability of a cooperative effort oriented toward the mutual professional development of both the US and Honduran medical forces." This was followed by a negotiated agreement whereby the 41st CSH would provide a paramedic course for the Honduran military.<sup>14</sup>

In order for an undertaking of such magnitude to succeed, coordination with key personnel of the Ministry of Health, the Honduran Surgeon General and COL Madrid, the Honduran Army G-5 was critical. COL Madrid turned out to be the central authority for humanitarian assistance approval within the Honduran military and gaining his approval and keeping him informed was key to success.<sup>15</sup>

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<sup>14</sup> Op cit, Zajchuk After Action Report, Section A, page 1.

<sup>15</sup> Ibid, Section A, page 1-2.

<sup>16</sup> Op cit, Zajchuk, p. 3; Zajchuk interview.



One problem encountered early was the potential of conflict with other health care organizations, religious groups, international agencies, and foreign countries promoting some type of health project for the populace. Workers from USAID, UNICEF, the European Economic Community (EEC), and the Swiss government were all in country carrying out sanitary construction projects.<sup>16</sup> The MOH attempted to coordinate and divide the country into respective work areas, but had found it rather difficult to coordinate the various groups. Incidences occurred where MEDCAPS/MEDRETES arrived at remote villages to discover another organization had just recently been there.<sup>17</sup>

Another area which could not be ignored is the respective departments and divisions of the MOH and Honduran medical system. Key departments, such as the Departments of Entomology, Epidemiology, and Preventive Medicine must be contacted and visited. Important information on the Honduran malaria control program, Chagas disease survey and control program, and pesticide testing program was discovered.<sup>18</sup>

These visits discovered several other interesting findings that future planners must be aware of when dealing with third world countries. First, the name of the government agency may sound impressive but the departments and divisions are under-resourced, understaffed, and lack modern technology. There was a desperate need of modern equipment, drugs, medical supplies, and transportation. Second, the point of contact for the MEDCAP must be fluent in Spanish. Coordinating the overall medical effort, maintaining the daily ongoing dialogue between local and MOH personnel and the Joint Task Force staffs is a full time job and absolutely essential to success or failure of the overall mission. And third,

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<sup>17</sup> Interviews with COL Charles Hood, Commander of JTF-B Medical Element, Palmerola Honduran Air Base, Honduras, 17-22 March 1988.

<sup>18</sup> Ibid, Hood interview, 21 March 1988.

<sup>19</sup> Op cit, Zajichuk interview.

when making contact visits, no promises should be made when confronted with requests for assistance.

It was recognized up front that it was essential to develop a mechanism for identifying, approving and reporting the humanitarian efforts. It was also recognized that the Honduran government must be the final approval authority.

Based upon a solid organizational foundation supported by all parties involved, the Medical Civic Action Program commenced. Villages were identified through coordination with local health authorities, final approval obtained from the Honduran Army G-5, and teams selected. Each MEDCAP site was selected two weeks in advance and located primarily around main US troop concentrations such as Comayagua and San Lorenzo. The 41st CSH was stationed near Comayagua and the 546th Medical Company (Clearing) was stationed at San Lorenzo. A reconnaissance team would visit each site, preferably one week in advance, and coordinate all efforts with the village leader. Landing zones, treatment areas, population size, and medical problems would be determined. Churches, schools, homes and open fields served as triage and treatment areas. In order to prioritize patients, the village leader was asked to prepare a list of patients to be seen. The teams consisted of Honduran and American physicians and nurses, medics, dentists, and veterinarians, required extensive logistic support, and were transported to the sites utilizing UH-60 Blackhawk helicopters.<sup>19</sup>

At the end of six months, a total of 135 MEDCAPS had been conducted treating 47,228 patients. See Table 1 for MEDCAP summary.

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<sup>20</sup> Op cit, Zajtchuk After Action Report, Summary of Honduran MEDCAP Data, Tab B-1.

TABLE 1. MEDCAP SUMMARY BY GEOGRAPHICAL AREA<sup>20</sup>

Area	No.	Medical Patients	Dental Patients	Veterinary Animals	Cost \$
Comayagua	74	22,010	4,553	36,934	40,659
Puerto Lampira	4	616	84	0	999
Aguacate	5	1,014	0	0	1,573
San Lorenzo	30	18,146	2,263	122	28,815
Puerto Castilla	22	5,442	489	11	8,647
Total	135	47,228	7,389	37,067	80,693

The MEDCAPS were a mirror-image of their Vietnam counterparts. The teams were composed of Honduran and American health care providers. They expended extra effort to convince the civilians that it was a Honduran military program and Americans were only assisting. Extensive use was made of village leaders to identify needy villagers. Educational classes were conducted by Honduran members of the team. Spanish speaking U.S. enlisted personnel were recruited to interpret and triage patients. And drug labels were printed in Spanish. Countering this strategy was the overwhelming presence of American personnel, aircraft, and equipment. Another important feature is these were one-day exercises conducted around large American troop concentrations. It must have appeared obvious to the surrounding villages that the northern "Americans" were embarked on a massive give-away program. For in essence, that is what these initial MEDCAPS were. Regardless of the humanitarian intent of alleviating human suffering and misery, they in reality accomplished little except to possibly improve the American image. Whether they will improve the image of the Honduran military in the eyes of their people is yet to be determined.

<sup>20</sup> Interview 15 March 1988 with MAJ Charles H. Gleaton who served as 7th Special Forces Group Surgeon, 1st Special Forces, Ft. Bragg, N.C., from July 1965 to July 1967. MAJ Gleaton served in Honduras multiple times during those years.

MEDCAP team procedure consisted of rolling into a village in the late morning, setting up shop, spending an average of only 5 minutes per patient in which time the physician was supposed to take a medical history (through an interpreter!), examine the patient, and give him medications.<sup>21</sup> The team boarded their aircraft for departure in the afternoon. Afternoon departure was dictated by internal security requirements forbidding night flights by American helicopters. The treatment lines were so long and time so short that adequate examinations became impossible. For the physician members of the teams, the exercise degenerated into drug handout sessions based upon the interpreters translation of the symptoms. Headaches received Aspirin, vaginal pruritis got creams, and so it went. Entomology support was also hampered. The entomologist was supposed to do vector surveys of the homes. However, all the villagers would be in town waiting in line. The Dental team members detected rampant carious lesions and pulled an average of 3 teeth per patient, the only service they provided. While the villagers appreciated the extractions, they showed no interest in the oral hygiene classes. One success was the veterinary portion of the MEDCAP which was well received by the villagers.<sup>22</sup>

The second issue that must be addressed is continuity of care. Obviously if the team discovered a severe disease that needed immediate medical attention, arrangements were made for treatment elsewhere. However, for the village this was their one-time shot at medical care. If they presented with anything more than a minor ailment, treatment was unavailable. Chronic diseases such as hypertension, arthritis, cardiovascular disease, cancer, and congenital defects could not be treated. The villagers with chronic diseases were instructed that they must

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<sup>22</sup> Ibid, Gleaton interview; Op cit, Hood interview.

<sup>23</sup> Interviews with Dr. Eduardo Retes, Honduran contract physician with JTF-B Medical Element, Palmerola Air Base, Honduras, 18-22 March 1988.

seek medical care from their local health care providers. Because of lack of resources, transportation, and money, it is doubtful whether any followed this advice.<sup>23</sup>

Pulling rotten carious teeth and teaching dental hygiene (brushing daily without toothpaste -- most villagers could not afford toothpaste) alleviated symptoms for possibly six years. Deworming children and adults lasted only as long as it took to ingest parasite eggs. As stated in the After Action Report, parasitic diseases were "the most common medical problem encountered."<sup>24</sup> Environmental sanitation problems are so significant that until these problems are addressed parasitic diseases will continue to be a major health problem in Honduras and other Central American countries.

In order to spread their resources to as many as possible, The 41st CSH MEDCAP teams did not visit the same village twice. However, since the 47th Field Hospital and the Medical Element JTF-B continued the program as developed by Zajtchuk, between 1984-87 the MEDCAPS apparently ended up returning to the same villages located around the large American troop concentrations. This was done mainly out of necessity and resource constraints. Overlooked was the important fact that most villages visited were considered to be better off than the very remote mountainous regions of the country and that local health care was already available.

Ministry of Health officials had some reservations about MEDCAPS and MEDRETES. They recognized that they were not reaching the areas that needed them most -- the inaccessible remote areas of the country without health care except for an occasional volunteer nurse.<sup>25</sup> Some alleged that the villagers thus

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<sup>24</sup> Op cit, Zajtchuk After Action Report, p. 5.

<sup>25</sup> Interview with Mr. Thomas Park, Director of USAID Human Resources Development Division, Tegucigalpa, Honduras, 23 March 1988.

<sup>26</sup> Op cit, Gleason.

became "sensitized" or "conditioned" to the teams quickly learning what symptoms to describe in order to acquire medications for either stocking their medicine cabinets or for selling on the blackmarket. One characterization was that the MEDCAPS became a giant "sick call" for large villages and did little for people except give away medications.<sup>26</sup> While admitting that significant amounts of drugs were dispensed, others contended that the physicians tailored their prescriptions to the needs of the patient particularly concentrating on the children. As a result, immunizations, deworming medications, and vitamins were common therapies.<sup>27</sup>

One problem difficult to analyze is what medical conditions were treated. While a total patient count was kept, no statistics could be discovered listing all the diagnosis and how many of each. Even the MEDRETE's today can't provide such data. By understanding how MEDCAPS are conducted, one can appreciate why such data is lacking. It is difficult to analyze the 1984-87 time frame as no after action reports were written following Zajtchuk's departure.

There is some suggestion that MEDCAPS were conducted like the Vietnam "body count" mentality. The measures of success were patients seen, teeth extracted, inoculations given, animals wormed, rather than lower infant mortality, decreased malaria rates, or increased life expectancy. The bigger the count, the better you must be doing. See as many as possible in as short as time as possible but don't worry about quality care.

Medical team members, however, do not share this mentality. They are extremely concerned about quality patient care, treating endemic disease, and caring for the sick. This theme surfaced time and time again in interviews with

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<sup>27</sup> Op cit, Hood interviews; Op cit, Zajtchuk interviews.

<sup>28</sup> Bruss, Don. The Emerging Role of US Military in Low-Intensity Conflict, Low Intensity Conflict and Modern Technology, 1985, p. 229.

medical personnel who had served on MEDCAP/MEDRETE exercises. Altruistic highly skilled health care professionals quickly become frustrated when denigrated to long sick call lines with no "end in sight." Health Care workers want to have an impact, to effect change, to extend the hand of assistance. How much good a MEDCAP has done is open to speculation when it withdraws, perhaps never to return. Short term objectives must be replaced by long term objectives.

The "body count" mentality is an administrative problem reserved for those who have no concept of long term objectives and need justification for resources allocation. The strategists and statisticians will obviously deduce from high body counts that the cost has been justified and American image enhanced. This maintains the continuity of the program (but not necessarily continuity of care). A most unfortunate aspect is that "body counts" are now institutionalized as a measure of success.

The basic problem was that the team visited large villages with prearranged arrival dates. This allowed citizens from surrounding villages to travel to the site for care. Upon arrival, the teams would be overwhelmed by the number of people waiting for services. Because almost all villagers, children and adults alike, suffered from malnutrition, anemia, and parasitism, everyone required health care. Since the Honduran medical system already had health care clinics in the large villages, we were in competition with local health care providers. A new policy was needed. One answer to this problem is scale the visits down to small villages with no health care and stay longer -- control patient input to guarantee improved health care and provide services to those with a genuine need. This new strategy removed a source of competition and disharmony between the Honduran medical system and our teams.

In some respects, MEDCAPS in Honduras are similar to Don Bruss' description of Vietnamese MEDCAPS. He stated, "MEDCAPS in Vietnam were not unlike creating a

hole in a glass of water with your finger. Once you remove your finger, the hole is gone and things return to normal. The MEDCAPS for all their good were in composite, little more than cosmetic efforts."<sup>28</sup>

Overall the MEDCAP program was well received by the Honduran Ministry of Health and the Honduran military. It succeeded in improving, at least temporarily, the medical/dental condition of some Honduran citizens and enhanced the American image in certain sectors of the country. Over 47,000 patients were evaluated, more than 21,000 teeth extracted, and over 37,000 animals treated. The ground work was established for working with the Preventive Medicine, Entomology and Epidemiology Departments to assist in malaria control and Chagas disease surveys. A total of 109 students were trained as Combat Medics for the Honduran military -- the core for developing a Honduran Military Medical Department.<sup>29</sup> A hospital medical maintenance program was initiated and surveyed twelve Honduran hospitals, trained Hondurans in medical maintenance, and assisted in placing medical equipment in service. The El Progreso Hospital which had been non-functional for four years was returned to service as a result of the 41st CSH assistance. During the exercise, the CSH also participated in the Honduran National Immunization Week, administering 202,339 immunizations, primarily polio, DPT, BCG, and measles.<sup>30</sup>

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<sup>29</sup> Op cit, Zajtchuk After Action Report, Executive Summary. p. 1.

<sup>30</sup> Ibid, page 2.



## **Chapter 4**

### **MEDICAL READINESS TRAINING EXERCISES (MEDRETES)**

Following the rebirth of MEDCAPS and the funding controversy that ensued, the medical presence was scaled back to an 88 personnel Medical Element.<sup>1</sup> The Medical Elements mission as delineated by SOUTHCOM remained unchanged -- provide medical support to the U.S. military on training exercises. The assumed MEDCAP mission also remain unchanged except for several important details. The name was changed to Medical Readiness Training Exercises (MEDRETES). Second, National Guard and US Army Reserve medical units, deploying for their annual active duty training in a field environment, would staff the exercises. And third, the focus was changed. MEDRETES were "training exercises" with the specific purpose of enhancing a persons ability to deliver health services under austere conditions.<sup>2</sup> Providing medical care in a tropical foreign environment introduced an element of realism they could not obtain elsewhere. Any benefit that accrued to the host nation or civilian population was considered "incidental" to the exercise.<sup>3</sup> "Training and incidental" were emphasized points due to Congressional interest and funding concerns.

A complicated scheduling board was established at the Medical Element Headquarters to track all incoming units and provide continuity for the program. The Medical Element Commander communicates his requirements to the SOUTHCOM surgeon who forwards it on to the FORSCOM surgeon for coordination with the National Guard Bureau (NGB), Office, Chief of Army Reserves (OCAR), and

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<sup>1</sup>Interviews with COL Charles Hood, Commander of JTF-B Medical Element, Palmerola Honduran Air Base, Honduras, 17-22 March 1988.

<sup>2</sup>Ibid, Hood interview.

<sup>3</sup>Thornton, William H. Army Medical Department Roles and Functions in Low Intensity Conflict, CLIC Papers, Army-Air Force Center for Low Intensity Conflict, Langley AFB, VA, Aug. 1987, p. 7.

the USAF. Scheduling of Army and Air Force rotating medical units was accomplished by their respective services. The MEDRETE requirements were based on the Medical Element Commander's estimate of what medical/dental specialties were required to accomplish his projected missions. These requirements were also determined by assistance requests from Honduran medical facilities, the MOH, and other contingencies. The services attempt to fill the requirements but unit manpower and medical speciality shortages cause shortfalls.

The program remained unchanged until 1987 when COL Michael Casey took command of the Medical Element and altered the exercises. His replacement, COL Charles Hood, continued his initiatives and embarked on further changes. Both commanders recognized that conducting sick calls and give-away programs in communities with existing health care was not furthering U.S. interests or achieving LIC doctrinal objectives. After coordination with the Ministry of Health and Honduran military (to the political dismay of some Hondurans who were receiving political gain from American health care providers in their districts), the program was redefined.<sup>4</sup>

The first and most important task was to clearly state the mission of the Medical Element. During the past five years, a number of missions had been assumed which expanded their roles beyond exclusive treatment of U.S. forces. (See Appendix A for complete list of Medical Element missions, principles, and goals). The additional missions are primarily aimed at accomplishing two objectives: educating U.S. military personnel on the realities of third world medicine and, on improving the overall Honduran health care delivery system.<sup>5</sup> With the receipt of HCA funds this year, increased emphasis can now be placed on this latter objective.

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<sup>4</sup> Op cit, Hood interview.

<sup>5</sup> Ibid, Hood interview.

The current program is designed to assist the Honduran government reach rural areas and people otherwise inaccessible. It has evolved out of unilateral one-day MEDCAPS for Hondurans into a bilateral joint fully coordinated US and Honduran effort. The intent is for the program to augment the existing Honduran health care system, not replace it. US resources are used to reach populations that the Honduran government cannot reach due to lack of resources. The overall objective is to work within the framework of the Honduran system.

The basic elements of the current civic and humanitarian action program are:

1. Honduran clinics. Two specific clinics are held: a general outpatient clinic and an Ulcer clinic at the Jose Cecilio Del Valle Clinic located adjacent to the Army hospital complex at Palmerola Air Base (see Appendix B). This clinic augments the Honduran private medical system by only providing general services and treatment of lower limb ulcers for patients referred by civilian physicians. This procedure establishes a working relationship between the American physicians and their Honduran counterparts and keeps the Honduran physicians involved in the treatment protocols. It also prevents Hondurans from avoiding their own medical system in preference to the American military system.<sup>6</sup>

2. MEDRETES. The major changes in MEDRETES was site selection and intent. The basic composition of the team consisted of American personnel augmented by a Honduran physicians, dentists, veterinarians, nurses, and medics. Thirty-three remote villages were selected by the Honduran government in the most sensitive areas of the country, especially Colon, Atlantida and Yoro provinces on the eastern Atlantic side. To be selected a village population must be less than 400, located in remote "suspect" areas, and meet specific poverty criteria -- no electricity, no medical care, no communication system, and poor to non-existent

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<sup>6</sup>Ibid, Hood interview; Interviews with Dr. Eduardo Retes, Honduran contract physician with JTF-B Medical Element, Palmerola Air Base, Honduras, 18-22 March 1988.

transportation. Each of the designated villages is scheduled for three visits per year for a period of 3-4 days each time. This allows the team adequate time to provide for medical/dental needs, collect medical statistical data on such interests as malaria and Chagas disease, educate and train, provide sanitation assistance, and treat animals. Continuity is provided through scheduled return trips. Of secondary worth is the medical information obtained for the Honduran Ministry of Health. Very little information is available on infant mortality or disease prevalence in the remote and sparsely settled regions of the country in which MEDRETES are now being conducted.

These three to four day training exercises are of invaluable worth to our reservists who practice their skills in a very primitive environment. Because of Congressional concern and government regulations, emphasis is placed on "training" of our medical personnel. This point is not lost on the opponents of any American presence in Honduras who claim Hondurans are being used as "guinea pigs" for US personnel. For this reason, the Medical Element has proposed a new term for their program, namely GUARDE, which stands for Guiar de Asistencia Resistencia De Enfermedades (Guided Assistance to Resistance to Sickness).<sup>7</sup>

3. Immunizations Readiness Training Exercises (IMRETES): Agreements have been reached whereby our medical teams will assist the Honduran national immunization program in rural areas and in the event of disease outbreak. IMRETES have been credited by USAID as the most effective US military medical program in the country.<sup>8</sup> Recently, an emergency Polio IMRETE was conducted 2-4 March 1988 by joint US and Honduran teams in an inaccessible area on the El

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<sup>7</sup>Ibid, Hood and Retes interviews.

<sup>8</sup>US Aid interview with Mr. Thomas Park, Director of USAID Human Resource Development Division, Tegucigalpa, Honduras, 23 March 1988.

Salvador and Guatemala border. This IMRETE was credited with stopping a polio epidemic.<sup>9</sup>

4. Specialty Teams: This is a fairly new concept with significant potential. Specific configured specialty teams, such as plastic surgeons, are brought into Honduras on a recurring basis to operate in Honduran hospitals on Honduran physician referred or MEDRETE identified patients. A plastic surgery team from William Beaumont Army Medical Center has been formed and already established a quarterly visit program to the Comayugua Honduran regional hospital (Santa Terresa). This team, called the JTF-Bravo Medical Element Plastic Surgery Augmentation Team, kicked off "Project Smile" on 30 Nov. 1987.<sup>10</sup> Not only did they see conditions not found commonly in the US, but they were able to provide invaluable training to Honduran physicians who joined their team. The public relations impact from their first surgical tour was covered extensively in local news accounts and was judged a resounding success.

The Medical Element Commander's goals are to expand the speciality team concept by enlisting support from other Military Medical Teaching Centers.<sup>11</sup> Not only will this provide invaluable training for our residents and faculty, but will support our National interests in helping to develop the Honduran health care system and foster American-Honduran relations. The visual impact on communities when previously disfigured children and adults return home and can lead normal lives is impressive. Costs of program will be provided by authorized Title 10 sources.

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<sup>9</sup>After action report, Polio IMRETE, JTF-B, Palmerola Air Base, Honduras, 7 March 1988.

<sup>10</sup>After Action report, JTF-Bravo Medical Element Plastic Surgery Augmentation Team, "Project Smile", 30 Nov. 1987-12 Dec. 1987, Department of Plastic Surgery, William Beaumont Army Medical Center, El Paso, TX.

<sup>11</sup>Op cit, Hood interview.

5. Development of a Humanitarian Effort for Long term benefit and Prevention (HELP) protocol (see Appendix C). This protocol, written by Dr. Eduardo Retes, a Honduran physician hired by the Medical Element to manage the MEDRETE activities, outlines the basic philosophies governing our Medical Element's humanitarian assistance program.<sup>12</sup> It establishes the basic framework in which the Medical Element carries out its assumed missions. This plan also describes how to interface with the Honduran Ministry of Health and meets Honduran health care goals and objectives. It emphasizes the necessity for Americans to work within the Honduran health care system. Dr. Retes emphatically stresses that team actions cannot create a dependency upon the Americans. He points out that when Americans pull out the Ministry of Health and the more than 5000 needy villages will still be there fighting the same problems.<sup>13</sup> Others expressed concerns that if our civic action programs are disorganized and ad hoc, they will in fact be destabilizing, raise the expectations of the people to unrealistic heights, and undermine the host government's programs. Our programs in fact can become a point of contention and an effective propaganda tool for insurgents.

Key objectives for civic and humanitarian programs in a low intensity environment are strengthening the stature and stability of the host government, enhancing the medical infrastructure, and as stated by James A. Taylor, "...to assist host countries in creating and nourishing a quality of life for their people that provides a viable alternative to the situation being developed by the Soviets and the Cubans."<sup>14</sup> This requires a dynamic problem oriented approach done in complete coordination and cooperation with the host nation. The current program

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<sup>12</sup>HELP SOP, provided by Dr. Retes, Honduran physician on JTF-B Medical Element staff, Palmerola Air Base, Honduras, 20 March 1988.

<sup>13</sup>Interview with Dr. Retes, Honduran staff physician, JTF-B Medical Element, Palmerola Air Base, Honduras, 18 March 1988.

<sup>14</sup>Taylor, James A. Military Medicine's Expanding Role in Low-Intensity Conflict, Military Medicine, April 1985, pp 27-34.

attempts to meet that requirement by basing their approach on the needs of the Honduran Government Ministry of Public Health and Social Service (Ministerio de Salud Publica Y Asistencia Social) and Military Health (Salud Militar) Department in conjunction with the U.S. Agency for International Development. This increased emphasis on coordination with the host nation has only been stressed in this program for the past six months.<sup>15</sup>

Designing a program that interfaces with the host nation's medical infrastructure and meets their long range goals requires a centralized command authority. This does not exist at present. Currently there are numerous independent U.S. military medical programs being conducted throughout the country which do not coordinate their activities with the JTF-B Medical Element Commander or the Honduran Ministry of Health. These range from small one-day MEDRETES being conducted by the 27th Engineer group in San Lorenzo and Puerto Lempira by two US Army physicians and a handful of medics to the five physicians and 50 medics supporting the Task Force 111 road building project who conduct "clinics" for civilians along the project route.<sup>16</sup> These are totally independent uncoordinated civic action/humanitarian assistance activities.<sup>17</sup> This is further complicated by the Special Operations Humanitarian Assistance Team (SOFHAT) operations conducted by the 7th Special Forces in the north-east "insurgency" region of the country. The 7th Special Forces have already conducted two iterations of extensive one-day MEDCAPS at numerous villages in that region.

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<sup>15</sup>Op cit, Hood interview; op cit, Park interview.

<sup>16</sup>Ibid. Hood.

<sup>17</sup>Interview 15 March 1988 with MAJ Charles H. Gleaton, MC, who served as 7th Special Forces Group Surgeon, 1st Special Forces, Ft. Bragg, N.C., from July 1985 to July 1987. MAJ Gleaton served in Honduras multiple times during those years; interview with MAJ K. N. Keenan, MC, Military Intelligence Battalion (LI), Palmerola Air Base, Honduras, 21 March 1988.

However, they encountered such difficulties that the next exercise, SOFHAT III, will be conducted by the JTF-B medical element instead of the 7th SF Group.<sup>18</sup>

The Medical Element Commander is finding it difficult coordinating and controlling the various diverse US medical elements scattered throughout the country who do not fall under his command authority. Hit-or-miss uncoordinated activities, while achieving short-term positive impacts, can actually do more harm than good in the long run. The overall goal of creating confidence in the local government may actually be undermined by traditional one-day "unofficial" MEDCAPS conducted by independent medical units in-country for short periods of time. Short term good will may be their only accomplishment. A single long-term program needs to be developed to support U.S. and Honduran interests. The Country Team should be given this responsibility. The Commander of JTF-B Medical Element should be tasked to help develop and implement the program. This would as a minimum require that the Commander of the Medical Element remain in country longer than 179 days. To realistically establish the necessary working relationships with host country leaders and develop and administer such a complex medical program requires the Medical Element Commander remain in country one to two years. This would add stability and continuity not now present.

The Ministry of Health and USAID now feel that the rural treatment program is meeting their requirements and desires. JTF-B Medical Element has successfully interfaced with the appropriate government departments and is jointly developing target populations, locations, treatment protocols, evacuation procedures, and referral procedures. Host government perceptions of our intentions is an important consideration when designing such programs. Success will elude us if we are perceived as embarking on nothing more than a "photo opportunity."

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<sup>18</sup>Op cit, Hood interview.



The evening news shows film clips of MEDCAP/MEDRETE missions in small Honduran villages. National newspapers and periodicals contain articles about the humanitarian good we are doing. Finally, the U.S. Congress now approves funds for HCA activities to be administered by the U.S. military. We are relearning the lessons of Vietnam.

## **Chapter 5**

### **Impediment to Success: Funding Issues**

Another issue that requires comment is funding. MEDCAPS were discontinued after Vietnam and no statutory authority for funding such an activity existed in 1983. Title 10 USC 124 prohibited the use of DOD-appropriated funds for humanitarian assistance.<sup>1</sup> All efforts to support low intensity conflicts, respond to USAID requests for assistance, and initiate medical civic action programs were unresourced. The use of Operations and Maintenance funds (OMA) to resource the AHUAS TARA II operations raised serious questions and caused a review by the Government Accounting Office (GAO) and Comptroller General.<sup>2</sup> The Comptroller General ruled in 1984 that DOD was in violation of Section 1301(c) of title 31 of the United States Code<sup>3</sup> and that civic and humanitarian activities undertaken by the Army fell under the Foreign Assistance Act.<sup>4</sup> DOD's position was that the activities were incidental to mission activities and were accomplished at no incremental cost to DOD.<sup>5</sup>

OMA funds were certainly justified for covering the costs of personnel, fuel, maintenance, repair of equipment and moving the unit to its overseas exercise and returning it home. GAO concern was over providing medical care to civilians and conflict with State Department missions. The initial Comptroller General opinion

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<sup>1</sup>Taylor, James A. Military Medicine's Expanding Role in Low-Intensity Conflict, Military Medicine, April 1985, p. 30.

<sup>2</sup>Interviews with COL Charles Hood, Commander of JTF-B Medical Element, Palmerola Honduran Air Base, Honduras, 17-22 March 1988; Memorandum for Deputy Under Secretary of Defense (Policy), Office of the Assistant Secretary of Defense, Washington, DC., 1 Apr 1986.

<sup>3</sup>Senate Report 636, 98th Congress, 2d Session 37, 1984.

<sup>4</sup>63 Comptroller General 422, 22-26, 1984.

<sup>5</sup>Comptroller General B-213137, 30 Jan. 86, p. 29.

stated that DOD did not have "inherent" authority to create incidental civic and humanitarian benefit during the performance of its mission. However, a second opinion reevaluating the first reversed this finding in favor of DOD in 1986.<sup>6</sup> The MEDCAPS were therefore justified on the basis of "training. This is consistent with Title 10 provisions that allows the use of DOD appropriated funds for the purpose of training and readiness.

DOD's "inherent ability" to create civic action programs was, however, limited by the following:<sup>7</sup>

1. The type and amount of activities must not fall within the scope of other appropriations.
2. The activities must be bona fide training for military participants.
3. The benefit conferred must be incidental to the bona fide training.
4. O&M expenditures must be made for the purpose of conducting the training, not providing the incidental benefit.
5. If there is another U.S. agency with authority to conduct activities similar to those DOD is performing, DOD should coordinate its activities with that organization.

The Comptroller General criticized AHUAS TARA II because no effort was made to relate its MEDCAPS to training requirements. Even though the MEDCAP mission has remained unchanged, the main difference now is that National Guard and U.S. Army Reserve Medical Units in country for two-week active duty training periods are conducting the exercises. The Comptroller General had no difficulty in relating

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<sup>6</sup>Legal Memorandum from Assistant Staff Judge Advocate, LTC Charles A. Byler, JA, USA, to Commander in Chief, US Pacific Command (USCINCPAC), 10 Nov. 1987.

<sup>7</sup>Ibid., DOD's Inherent Ability to Create Civic and Humanitarian Benefit While Conducting Bona Field Training Activities, Enclosure (1) to Legal Memorandum.

post-AHUAS TARA II activities to training and ruling they were legal under U.S. Code Title 10, Chap. 20.<sup>8</sup>

The Comptroller General also felt that U.S. Army medical efforts possibly duplicated or even contradicted USAID efforts in Honduras. USAID was engaged in a long-range program to assist development of the Honduran medical health care system and suddenly found itself confronted with a short-term Army program with the same objectives.

In 1984, the authority to expend O&M funds for civic and humanitarian assistance projects incidental to JCS exercises was enacted by the Stevens Amendment (Section 8103).<sup>9</sup> The Stevens Amendment authorized OMA funds for FY 85, FY 86, and FY 87 but was not reenacted in FY 88.<sup>10</sup>

In 1987, Congress passed Section 333 of the DOD Authorization Act, and finally recognized DOD's role in conducting humanitarian assistance programs and created a separate funding authority for such activities, appropriating \$3 million for fiscal year 1987 and \$16.4 million for fiscal years 1987 through 1991.<sup>11</sup> In chapter 403 they specifically stated, "Expenses incurred as a direct result of providing humanitarian and civic assistance under this chapter to a foreign country shall be paid for out of funds specifically appropriated for such purpose" and "Nothing in this chapter may be interpreted to preclude the incurring of minimal expenditures by the Department of Defense for purposes of humanitarian and civic assistance out

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<sup>8</sup>Ibid, Legal Memorandum.

<sup>9</sup>22 U.S.C. Section 8103; Legal Memorandum from Assistant Staff Judge Advocate, LTC Charles A. Byler, JA, USA, to Commander in Chief, US Pacific Command (USCINCPAC), 10 Nov. 1987, Enclosure 2.

<sup>10</sup>Message to CDR JTF-B, 251200Z Jan 88, from CDR USSOUTHCOM.

<sup>11</sup>DOD Authorization Act, 1987, Section 333, P.L. 99-661.

of funds other than funds appropriated pursuant to subsection (a)".<sup>12</sup> Section 333 specifically recognized the treatment of civilians as an exercise activity.

The issue also became immersed in controversy over the definition of what constitutes major and minor assistance. The Stevens amendment implied "minor" amounts of humanitarian assistance unrelated to training requirements was acceptable. Major activities were not. Is treating 50,000 medical patients, 10,000 dental patients, and 13,000 animals over a 100-week period in 1984 major or minor? Only by completely understanding what a MEDCAP/MEDRETE is can you render a fair answer to that question. However, it appeared to some government officials that the large scale OMA funded civic and humanitarian efforts that continue in Honduras go beyond the limited authority of Section 8103 and that AHUAS TARA II MEDCAPS exceeded their funding authority.

The AHUAS TARA II MEDCAP is a fait accompli. MEDRETES are not. Congress enacted Section 333 of the DOD Authorization Act, 1986, and now Title 10, US Code has been amended legally authorizing humanitarian and civic action programs in conjunction with military operations. This was an important Secretary of Defense initiative proposing legislative changes to Title 10.<sup>13</sup> The new changes require approval by the Secretary of State, USAID, and the Country Team of any humanitarian and civic action program undertaken by the U.S. military. This is an outgrowth of criticism leveled at the Honduran MEDCAPS AND MEDRETES that little, if any, coordination was carried out with USAID. USAID operates a \$26 million

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<sup>12</sup>Ibid, Section 403.

<sup>13</sup>Memorandum for the Deputy Under Secretary of Defense (Policy), subject: State Department Concerns about Proposed Title 10 Legislation, 1 April 1986, Office of the Assistant Secretary of Defense, Washington, D.C.; Letter to Honorable Thomas P. O'Neill, Jr., Speaker of the House of Representatives, from General Counsel of the Department of Defense, Washington, D.C., 1986.

health sector project intended to assist the Honduran Minister of Health develop community-based health outreach programs.<sup>14</sup>

The failure to enact the Stevens amendment for FY 1988 caused some consternation at JTF-B Medical Element Headquarters until they were notified that SOUTHCOM had been authorized Title 10 Humanitarian Civil Affairs (HCA) funds for humanitarian and civic action programs. This precipitated a frenzy of planning action on how to utilize the \$750,000 they were authorized for the coming 12 months or \$1.5 million over the next 18 months (see Appendix D).<sup>15</sup> It would appear that today's field medical staffs, while prepared to run MEDCAPS/MEDRETES, have little experience in humanitarian and civic action planning with long range objectives. This is further complicated by the six month assignment limitation for all members of JTF-B, including the commander of the Medical Element. Developing long term goals and seeing them carried to completion is impossible. Future commanders may even change the objectives. Short term accomplishments are much easier to measure. The Country Team should be organized to properly utilize funds authorized by Title 10 or the funds may end up being squandered on an endless sea of humanity with no beneficial results.

Funding has remained a problem since MEDCAPS were initiated in 1983. It will probably remain one for some time regardless of recent Congressional actions and Title 10 HCA funds. Budgetary and fiscal constraints now being imposed upon DOD may impact severely upon future humanitarian and civic action programs. SOUTHCOM's position is that civic or humanitarian assistance related activities are

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<sup>14</sup>22 U.S.C. Section 8103; Legal Memorandum from Assistant Staff Judge Advocate, LTC Charles A. Byler, JA, USA, to Commander in Chief, US Pacific Command (USCINCPAC), 10 Nov. 1987, "DOD's Ability to Conduct Civic and Humanitarian Activities in Conjunction with a JCS-Sponsored Exercise", Enclosure 2, page 2.

<sup>15</sup>Op cit, Hood interviews.

necessary to meet training requirements and SOUTHCOM will continue to expend training funds to support MEDKETES. National Guard and US Army Reserve Units will probably continue to support the program as long as training funds are available. The HCA funds have their own set of restrictions and must be used specifically for civic and humanitarian action programs in a rural setting. They cannot be used for US military or host nation military personnel<sup>16</sup>

This problem of funding and support has been further compounded by a general reluctance among the Services to support humanitarian assistance since it detracts from the military's ability to provide peacetime medical services to active duty, dependents and retirees. This was particularly true during the 1970's acute military physician shortage. In today's era of shrinking resources and inadequate staffing of military treatment facilities, taskings to support humanitarian assistance programs in third world countries places an undue hardship upon the Service's medical departments. Some even believe that participation in humanitarian assistance programs detracts from the overall mission of warfighting and military readiness. The establishment of clear national priorities should help resolve this question.

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<sup>16</sup>Op cit, Hood interviews.

## **Chapter 6**

### **Conclusions and Recommendations**

Central American countries suffer from widespread disease, poor sanitation, illiteracy, and high infant mortality rates. Central America also suffers from unstable governments, corrupt politicians, revolution and low intensity conflict.<sup>1</sup>

The Vietnam model, on which current military sponsored humanitarian assistance doctrine and programs are based, consists of a MEDCAP/MEDRETE team entering a village, establishing lines for physical examinations and treatments, dental exams and extractions, inoculations, and an animal treatment area. Sanitation surveys are performed and oral hygiene and sanitation classes conducted. Therapeutic drugs (vitamins, antibiotics, antihelminthics) are handed out in large amounts. After everyone is seen, the team would pack its bags, leave, and the village returns to normal. Is this approach bad? It depends upon your objectives, whether short or long term.

Obviously, the Vietnam model is a short term cosmetic approach with few, unmeasurable long term effects. It creates good will for the moment, if exploited by the host nation. The psychological objective is to primarily impress villagers that the government cares about them and is finally doing something to improve their condition. A secondary objective is that the Americans, as guests of their country, are assisting these efforts.

After the team leaves and, if the government is never seen again, the only long-term effects are perhaps missing teeth. Poverty, survival subsistence, disease,

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<sup>1</sup>Interviews with COL Charles Hood, Commander of JTF-B Medical Element, Palmerola Honduran Air Base, Honduras, 17-22 March 1988.



malnutrition, parasites, malaria, dirt and filth are what I mean when I say the "village life returns to normal." For a commander in the field, the short-term effects can be significant particularly if he is combating a growing insurgency and depends upon the good will of the native population. However, field commanders do not have the resources to develop health care systems, solve sanitation dilemmas, dig wells, and change life styles that have evolved over centuries. This requires a comprehensive strategy and assistance plan beginning with the health care delivery system of the host nation.

The challenge in low-intensity conflict is to develop military and civilian health care systems capable of meeting the basic needs of the population and military forces. A basic health care system needs to reach the grass roots areas of the population before insurgency forces have an opportunity to flourish. Several medical mobile teams have recently been dispatched to developing countries to help them develop their emerging or almost non-existent military medical systems. The most publicized has been the team dispatched by President Reagan in 1983 to El Salvador.<sup>2</sup> Other teams are operating in Saudi Arabia and Jordan.<sup>3</sup> These are the first in what should be a continued strategy for developing long term objectives. However, while they may solve the host nations military medical problems, their effects do not reach into the grass roots civilian sector where insurgencies use the lack of medical care to their advantage.

There are numerous organizations/and or individuals who may make determinations that a health service requirement exists in a given country. Regardless of how the requirement is determined, proper coordination is essential for maximum success. USAID, the Ambassador, Peace Corps, CINC, and Country

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<sup>2</sup>Zajtchuk, Russ and Winkler, William P. Jr. Medical Assistance as an Instrument of U.S. Policy in Developing Countries, unpublished paper, pp. 1-7, 1988.

<sup>3</sup>Bruss, Don. The Emerging Role of US Military in Low-Intensity Conflict, Low Intensity Conflict and Modern Technology, 1985, p. 232.

Team must be involved in the planning process to ensure that medical resources are appropriately allocated and long-term oversight is maintained. The agency charged by federal law with assisting developing countries is USAID.<sup>4</sup> The military services with their extensive resources, mobility and expertise can complement State Department objectives. Each agency or Federal service has strengths and weaknesses that can be exploited for maximum effectiveness. All goals and objectives must be clearly defined to assure cooperation and a harmonious working relationship.

The US Army medical department is now involved in writing low intensity conflict doctrine that should have positive impact on future operations. One individual within the AMEDD should be given the responsibility of developing AMEDD LIC doctrine. Lines of authority and coordination must be clear. Congressional actions are untangling the legal morass, resolving funding issues, and clarifying roles. It is now recognized that medical operations in low intensity conflict scenarios represent the most cost effective and least controversial technique for gaining popular support.<sup>5</sup> At minimal cost positive relationships can be established between native populations and their military forces, American image significantly enhanced, and the foundation established for an improved health care system in a developing country.

Requests for US military medical involvement in third world countries have increased over the past few years and the demand is expected to continue. Countries such as Guatemala that would not allow access to US military personnel allowed our military medical personnel to enter.<sup>6</sup> DOD, DA, the CINCS, and country teams are now beginning to recognize the valuable role the AMEDD can play in such

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<sup>4</sup>Ibid, p. 226.

<sup>5</sup>Briefing to GEN Maxwell Thurman on "The Medical Role in Low Intensity Conflict" by the Academy of Health Sciences, Feb. 1984, pp. 1-21.

<sup>6</sup>Ibid, p. 2.

operations. SOUTHCOM's unyielding support for the Honduran humanitarian and civic action programs is a case in point.

Honduras is an excellent example of launching a broad comprehensive program designed to counter the root causes of an insurgency. Besides being an ally and long time friend, Honduras merits U.S. support as a poverty stricken third world country. Not only is it the poorest country in Central America, but it suffers from an alarmingly high illiteracy rate (40%); a phenomenal infant mortality rate of 78.6 per 1,000; and a fertility rate of 6.1 per woman. It must meet this challenge with only 2.1 physicians per 10,000 inhabitants.<sup>7</sup> The ministry of Health does not have the resources or funds to care for the nation. Even though there are 3,000 doctors in country (another 1,000 have left via the brain drain phenomenon), 1,000 are unable to find employment due to the poverty standards of the nation.<sup>8</sup> The rest are located in the few main cities, causing a severe maldistribution of a valuable national resource.<sup>9</sup> Filth, pollution, poor sanitation, unsafe water, and rampant disease are the normal experience of all but a few.

Regardless of these conditions, the Hondurans have organized an excellent health care system that extends from the regional hospitals to the basic Cesar, or community nurse, found in the remote villages (see Appendix E).<sup>10</sup> The problem stems from a lack of basic equipment, supplies, technicians, drugs, and funds. What they don't need is high technology. A case in point is the recent construction and equipping of a hospital by USAID in Puerto Lempira. The Hondurans could not

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<sup>7</sup>Honduran Health Care Fact Sheet, provided by COL Charles Hood, Palmerola Air Base, Honduras, 18 March 1988; Honduras, A Country Study, Foreign Area Studies, The American University, Edited by James D. Rudolph, U.S. Government Printing Office, Washington, D.C., pp. 63-65

<sup>8</sup>Interviews with Dr. Eduardo Retes, Honduran contract physician with JTF-B Medical Element, Palmerola Air Base, Honduras, 18-22 March 1988.

<sup>9</sup>Medical Capabilities Study Republic of Honduras (U), Defense Intelligence Agency, Armed Forces Medical Intelligence Center, 31 Aug. 1985, pp. 31-36.

<sup>10</sup>*Ibid.*, pp. 42-43.

afford to purchase the fuel to run the generators and thus the hospital sits idle.<sup>11</sup> When high technology such as sterilizers, X-ray equipment and boilers breaks, they do not have the funds for repair, nor do they have the trained technicians to fix the equipment. These are conditions Westerners would find intolerable in their own countries. In developing countries these circumstances are reality. These problems breed high infant mortality rates, high birth rates, short life spans, and become the spawning grounds of revolution for a people crying out for a better way of life. They are a proud people and the MOH is not interested in a bunch of US military physicians running throughout their country disrupting a system they are trying to build.

If we seriously desire to assist in nation building, we must work within their system. We must help them build programs that will maintain their populations allegiance to the government. To do this we should provide training at all technical skill levels. As so clearly stated by Dr. K. K. Dass, Indian Ministry of Health, "What we need are doctors, scientists, and medical administrators who will mingle the experience and conventional wisdom of our country with the science of the West, and produce a synthesis suitable to our country. What we get are exact copies of the West...."<sup>12</sup> This excellent advice should be kept in mind by U.S. health care planners.

It must be recognized that no matter how well-intentioned we are, we cannot feed, educate, clothe, and provide medical care to another country's people without undermining its government. India has criticized aid because it stunts development of their own medical systems, undermines programs, and depresses

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<sup>11</sup>After Action Report: Assistance Visit to Centro de Salud, Puerto Lempira, Gracias A Dios Province, by Colonel Charles H. Hood, Commander, Joint Task Force Bravo Medical Element, Palmerola Air Base, Honduras, 29 February 1988, pp. 1-3.

<sup>12</sup>Dass, K. K. Medical Aid to Developing Countries, The Journal of Tropical Medicine and Hygiene, V.77(Nos. 1-12), Jan-Dec. 1974, pp. 275-277.

the national will.<sup>13</sup> Our responsibility is to provide the expertise and resources to make "their" programs work. I emphasize the word "their" because traditionally MEDCAPS/MEDRETES are American concepts introduced into foreign health care systems. When we leave, the concept vanishes.

Our goals must be consistent with those stated by the Bipartisan Commission in 1984 when they recommended the following National objectives for Central America:<sup>14</sup>

1. The reduction of malnutrition.
2. The elimination of illiteracy.
3. Universal access to primary education.
4. Universal access to primary health care.
5. A significant reduction of infant mortality.
6. A sustained reduction in population growth rates.
7. A significant improvement in housing.

Goals 3,4 & 5 must go hand in hand. To reduce infant mortality and increase life spans without reducing population growth rates will invite disaster.<sup>15</sup>

The U.S. Armed Forces Medical Departments have a proud tradition and heritage of providing humanitarian care. They have broad and expansive research and development programs with an extensive background in third world country diseases. And they have the capability to "project power" or otherwords, deploy worldwide. This provides the United States with a unique opportunity to assist

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<sup>13</sup>Op cit, Dass, p 276; Dass, K.K. Medical Aid to Developing Countries, The Lancet, p. 1373, June 21, 1975.

<sup>14</sup>Report of the Bipartisan commission on Central America, Chap. 5, Washington D.C., January 1985, p. 1.

<sup>15</sup>Op Cit, Dass p. 275.

developing nations. However, even minimal success cannot be attained without a realistic assessment of the conditions and needs of these countries.<sup>16</sup>

U.S. military forces on exercise within a third world country are there at the invitation of those countries internationally recognized leaders. Our MEDCAPS/MEDRETES are not. There has been no request, either from the host-nation's political leaders, USAID, or the Ministry of Health. It's after our medical support team has arrived in country to support our deployed troops that we attempt, with good intentions, to provide Western medicine to an impoverished people. We then negotiate with the host government a "quick-fix" solution to a centuries old medical problem. Our MEDCAPS are conducted like military operation -- solve the problem as quick as possible and leave. Therein lies the dilemma and potential for conflict.

Our special forces medical teams deployed in the remote countryside have learned the value of providing medical care to win the short-term support of the peasants. To complicate matters, special forces teams do not coordinate their one-day MEDRETE activities with either the Ministry of Health or the Medical element Commander at JTF-B.<sup>17</sup> Independent, uncoordinated small medical teams roaming the countryside and sponsoring one-day activities are counterproductive to the overall objective of nation building. Their actions are like holding water in your hand. It just runs through them. It is reasonable for USAID to be disturbed by these uncoordinated programs with short-term objectives that possibly duplicate or interfere with their long term medical assistance plan.

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<sup>16</sup>Hendley, James Williamson. Health Services as an Instrument of United States Foreign Policy Toward the Lesser Developed Nations. University of Iowa, Ann Arbor, University Microfilm, 1971, p. 26.

<sup>17</sup>Interview 15 March 1988 with MAJ Charles H. Gleaton who served as 7th Special Forces Group Surgeon, 1st Special Forces, Ft. Bragg, N.C., from July 1985 to July 1987. MAJ Gleaton served in Honduras multiple times during those years.

Although our medical intentions are well meaning, unless the military medical civic and humanitarian action plan is organized, coordinated, and centrally managed by responsible individuals who are capable of dealing with indigenous government personnel, the program will not achieve its potential. It is essential that we understand the goals of the lesser developed nation, the aspirations of the leaders, and the values upon which these aspirations are founded. In addition, the peasant culture must be understood as well as the differences that exist between them and the other socio-economic classes. A well thought-out program consistent with host nation long term medical objectives should be developed. MEDCAPS/MEDRETES, while an element of this plan, should not be construed as the only solution to a complex problem.

MEDCAPS/MEDRETES are effective programs for meeting the CINC's requirements to enhance the U.S. image, counter low intensity insurgencies, and conduct readiness training. As constituted, the program currently directed by JTF-B has evolved into a superb effort. While this has required time, the keen understanding of internal Central American problems by the present commander and his predecessor has fostered positive relations with the Honduran health care leaders and cemented the crucial lines of communication between USAID, JTF-B and the Honduran health care system. The one missing ingredient for US medical units deployed in direct or indirect support of counter-insurgency/LIC operations is the lack of a mission statement. This is not uncommon. There appears to be a reluctance to officially recognize the important role that medical support units can play in the LIC environment. All too often medical units assume this mission in recognition that they constitute a powerful tool to support the overall US military mission and US interests as well as support the host nation population.

The recent authorization of Title 10 money for military humanitarian and civic action programs should impact on current thought and doctrine and dictate an

important change in philosophy whereby a Combat Service Support organization assumes an "operational" mission. Indeed, this is a novel approach and represents new doctrine for the AMEDD. Moving from a "reactive" to a "proactive" posture in the LIC environment in support of National interests and CINC missions requires innovative planning, coordination, and execution. Indeed, Combat Service and Combat Service Support units acting under an expanded Security Assistance program may well prove to be the best medium for meeting our Security Assistance objectives.

The current medical civic action program in Honduras, while accomplishing short-term objectives, is seriously hampered by critical flaws. If the only objectives are creating short-term good will and providing training for U.S. military personnel, then the MEDRETES are a resounding success. Working with allies, testing field equipment, and training U.S. soldiers in austere conditions improves our readiness posture. If the objective is to counter insurgencies at the grass roots level by eliminating a major cause of socio-economic discontent, then there are serious problems. The major problem is the lack of approved AMEDD LIC doctrine and policy. While this doctrine is now being developed, the AMEDD may not be prepared to support it due to resource and manpower constraints and the peacetime health care demands. A clear definition of the mission of the AMEDD in low intensity conflict is the first priority. The second key issue is the lack of a military health care foreign assistance policy. Doctrine, policy, and commitment by the U.S. Congress, DOD, and AMEDD for a sound long-term nation building program is the foundation of meaningful civic action initiatives.

The operational problems are significant. There is no mission statement from SOUTHCOM or the AMEDD concerning MEDRETE activities in Honduras. There is a clear lack of policy and doctrine to guide hospital field commanders on what objectives to achieve, or how to achieve them. The entire program has evolved



from good intentions -- commanders recognizing a problem exists and then attempting to solve it. This is compounded by a lack of centralized command, control, and planning. Every medical element, from special forces to medics supporting road building projects, is running their own civic action program. There is a lack of coordination between the various U.S. medical elements, U.S. agencies, and the Honduran MOH. The exercises have been carried out under the pretense of training to justify fund expenditures -- operating on the edge of legality.

The only positive element is that the current Medical Element Commander clearly recognizes the problems and has initiated corrective steps. He is now coordinating all exercises with the MOH and attempting to exercise command and control over all U.S. military medical elements in-country. He is writing policy and doctrine for a long-range program that will support the Honduran medical program. The humanitarian and civic action program currently being run by JTF-B has the potential of becoming the forerunner for future nation building projects. It is my contention that these operational problems will not be solved until such time as clear doctrine and policy is formulated, missions defined, a centralized planning activity organized, command and control established, and the mission resourced with appropriate manpower and funds.

### **RECOMMENDATIONS**

The expanding role of military medicine in low intensity conflict can be realized by the following nine recommendations:

1. Doctrine and Policy. Clear National, DOD, and AMEDD doctrine and policy on military medical civic and humanitarian action programs must be formulated. This is the foundation for all future courses of action.
2. Mission. The AMEDD should be given the mission of humanitarian and civic action programs in support of LIC doctrine. This mission must be resourced

with funds and manpower. Today's burdensome peacetime health care mission does not allow the AMEDD the flexibility of assuming the LIC mission without adequate resourcing.

3. **Medical Readiness.** Maintenance of medical readiness for active duty and reservist medical personnel must be supported and not just given lip service. MEDCAPS/MEDRETES represent the only opportunity to provide realistic training, deploy medical forces, test field equipment, and conduct readiness-related medical research. The program should be expanded to include large numbers of active duty medical forces, not just reservists. The program of training U.S. medical specialists (select residencies) in third world countries should be expanded. Field equipment should be tested in the real-world environment.

4. **Command and Control.** A staff surgeon should be assigned to the Country Team for the specific purpose of running civic action programs, managing HCA funds, and coordinating with all U.S. and host nation agencies.

5. **Training.** Qualified medical personnel should be identified and trained to deal with the LIC environment. These individuals should acquire skills and expertise necessary for interaction with host nation medical systems, U.S. government agencies, and international organizations. Special training programs such be developed for this purpose. In addition, a career path should be established for select medical personnel to be trained as Foreign Area Specialists. This will provide the expertise necessary for select surgeons to be maximally effective when serving on Country Teams. Fluency in the host nation's language should be mandatory.

6. **Coordination.** All programs should be fully coordinated. This includes key U.S. agencies, international organizations, host nation Ministries of Health and subordinate agencies, and all branches of the U.S. and host nation military. Close coordination with USAID and the State Department will reduce confusion, prevent

internal conflicts, and eliminate overlapping programs. This allows maximum utilization of scarce resources. The U.S. military and USAID should engage in operational planning and mutual goal setting at the highest organizational levels.

7. Training of foreign personnel. Funds and resources should be allocated for training medical personnel in the United States, either at civilian or military educational facilities. Government sponsored scholarships should be expanded significantly to bring Latin American students to the United States. This includes training for such career fields as nurses, technicians, physicians, and administrators. All foreigners should return to their native countries upon completion of training. Legal requirement to ensure this should be pursued.

8. Long-Range vs. Short-Range Programs. To counter insurgencies in their infancies, long-range humanitarian and civic action programs must be developed to eliminate the root causes of population discontent before commitment of troops is necessary. Senior military leaders must be convinced that the AMEDD can play an important role in this arena. The Academy of Health Sciences should be tasked to develop these programs for implementation in specific third world countries. At the same time, short term objectives such as construction of wells and sanitary landfills can assist USAID's long term plans. All short and long-term objectives should be coordinated with USAID to prevent supplanting USAID's long-term nation building efforts.

9. Host Nation Medical System. All humanitarian and civic action programs must be fully coordinated with the host nation ministry of health, medical infrastructure, and military medical system. Our programs must work from within their system, not replace it. Our objective must be to assist the host nation develop its own medical program of providing health services to its population. At no time must we be seen as an alternate health care system or "give away" program. The host nation should take the lead in all exercises. The U.S. military medical

establishment should assist where basic human needs far outstrip the available resources. Our programs should solve nutrition, sanitation, and personal hygiene problems. Garbage disposal, potable water, basic health education, vector control, family planning, and immunizations should be included. Our programs should not provide high technology to developing countries. Medical evacuation, logistics, and medical maintenance systems should be developed in-country when feasible.

Military humanitarian and civic action programs have the potential to be powerful foreign policy tools in countering insurgencies in third world countries. The objective of medical involvement is to improve the quality of life for a third world nation and positively influence their values toward democracy. Medical counter-insurgency strategy can neutralize one of the root causes of population dissatisfaction that insurgents target. MEDCAPS/MEDRETES should be part of an overall task force master plan. Uncoordinated ad hoc exercises can actually do more harm than good. The Army Medical Department must be ready to support Department of Defense low intensity conflict strategies. Nation building is an appropriate role for the Army Medical Department in support of U.S. national foreign policy interests.

**Appendix A**  
**JTF-B Medical Element Missions**

- I. Provide medical support for all US military forces deployed in Honduras.**
- II. Train stateside deploying medical units on Honduran unique problems.**
  - A. Tropical developing country typical problems**
    - 1. High infant mortality
    - 2. Infectious diseases
    - 3. Areas of emphasis: poor sanitation, malnutrition, parasites
    - 4. Tropical diseases: malaria, dengue, leishmaniasis, chagas
  - B. Coordinate Medical Readiness Training Exercises (MEDRETES)**
- III. Provide medical support for contingencies.**
  - A. U.S. military operations/exercises**
  - B. Disaster assistance: including earthquake, flood, hurricanes**
- IV. Test and validate doctrine for employment of military assets in LIC.**
- V. Provide humanitarian assistance**
  - A. Preventive in focus**
    - 1. Human and animal vaccines
    - 2. Preventive dentistry
    - 3. Nutrition education and information
    - 4. Focus on rural primary care provider tools

**Note: Only Mission I is assigned. All other missions are assumed.**

## **JTF-B MEDICAL ELEMENT HUMANITARIAN AND CIVIC ACTION PROGRAM PRINCIPLES**

1. Based on Honduran agreement and cooperation
2. Two year long term plan
3. Active dialogue with US Embassy, USAID, and MILGRP
4. Liaison to Salud Militar and Ministerio de Salud
5. Bridge to Honduran Medical Academia
6. Incorporate all U.S. Military medical presence in country:
  - JTF-B Medical Element
  - Gorgas Memorial Laboratory teams
  - SOFHAT
  - TF111
  - 44th Med Bde
7. Provide material and clinical support to the Honduran medical system
8. Conduct Jose Cecilio Del Valle Clinic (Palmerola HAFB) Tuesday and Thursday for referred Honduran civilians.
9. Conduct Ulcer Clinic (Palmerola HAFB) Wednesday at the Del Valle Clinic
10. Provide inpatient and operating room support for referred Honduran civilians at JTF-B Medical Element hospital
11. Conduct MEDRETES in conjunction with Honduran Health System
12. Conduct Regional Health Surveys (medical and veterinary)
13. Assist in health and sanitation teaching
14. Emphasize tropical medicine
15. Obtain mission recognition

16. Increased emphasis on communication and coordination with all parties (incoming reservists, Honduran military, Gorgas Army Hospital, SOUTHCOM, Honduran medical system)
17. Provide continuity of care

### **JTF-B MEDICAL ELEMENT GOALS**

1. Arrange for training of Honduran preventive medicine, veterinary medicine, and medical maintenance technicians at the Academy of Health Sciences.
2. Arrange for American residents, internists and technicians to obtain training in Honduras.
3. Arrange for Specialty Teams (e.g. plastic surgery, ophthalmology, otolaryngology) from the Military Medical Centers to conduct programs out of local Honduran hospitals.
4. Assist the Hondurans in the performance of disease surveys for malaria, chagas, and dengue.
5. Assist the Honduran Veterinary Department establish programs to identify and treat Bovine tuberculosis, Brucella, and screwworm.

APPENDIX B

HONDURAN CLINIC "JOSE CECILIO DEL VALLE"

This is a service to supplement the Honduran Health System care. We take care of Honduran patients referred to us by a physician, or patients with emergencies. Patients not referred by a physician will not be seen. This clinic runs on Tuesday and Thursday at 10:00 hours, each week we offer the following services:

- a. Ward with 12 beds
- b. EMT
- c. Basic X Ray
- d. Basic Lab
- e. Pharmacy
- f. Dental Clinic
- g. One O.R.

We are staffed with 10 doctors:

- 4 General Physicians
- 2 General Surgeons
- 2 Dentists
- 1 Internist
- 1 Orthopedic Surgeon

The following number of patients can be served each Tuesday and Thursday:

Dental Clinic	40 patients (only extractions)
Surgery	5-10 patients
Orthopedics	15 patients
General Medicine	50 patients
Ulcer clinic	20 patients

This clinic is conducted on Wednesday and is for ulcers on lower limbs due to circulatory stasis (venous).

The requirements to be seen are:

1. Have a referral sheet from the Ministry of Health with the name and signature of the physician and the stamp of the health center.
2. The service will be free of charge. The referring physician should explain the reason for the referral.
3. The patients should bring the Honduran ID card or any ID card.

We would welcome a visit from you. We want you to see our hospital. Our doctors and nurses can explain what we can and can't do. We are eager to better serve the patients and to be good neighbors to our Honduran colleagues.

Please contact us at 31-5300/72-0454 ext. 153



COL CHARLES HOOD  
Hospital Commander  
JTF-Bravo Medical Element



*Written by Dr.  
Retes*

H.E.L.P. SOP  
(Humanitarian Effort for Longterm benefit and Prevention)

I. PHILOSOPHY:

- Supplement the Honduran Health Care System which has lack of resources and limitations.
- Upgrade the existing health conditions and meet the medical needs of the people.
- The activities may be closely coordinated with the Honduran Ministry of Public Health to ensure that our mission is not counterproductive.
- Gain influence over the population and to promote loyalty over to insurgent members in Honduras.
- Improve the quality of life and medical services provided by the Honduran government.
- Promote longterm benefits to the population.
- Change the idea that the Americans are "Gods and have miracle drugs". This will create a bad image of the Honduran Health Care and will have a long-term bad impact for Honduras and the population.

II. PERSONNEL:

- a) Mission OIC/NCOIC
- b) Hondurans: every mission should be accompanied by a Honduran physician, dentist, and nurse to ensure the Honduran presence in a joint mission.
- c) Clinicians
- d) Pharmacy
- e) Preventive Medicine Section
- f) Dental Section
- g) Veterinary Section
- h) Translators
- i) Security Section
- j) Communication
- k) Self help projects and training programs for health personnel.
- l) Laboratory Section (TB, Leishmaniasis, Chagas, Malaria, TBC)

a) OIC/NCOIC:

- Coordinate with the Ministry of Public Health at the different levels: Regional, Area, CESAMO, CESAR, according to the Commander's Policy.
- Conduct recon of the village and involve health workers and the community to ensure a joint effort.
- Organize the different sections to best meet the needs of the village (according to the recon).
- Plan the mission.
- Ensure that all the members are qualified to work in their sections.
- Briefings and supervision.
- Security.

b) Honduran Personnel:

The more Hondurans that are involved the better for the mission, because we want to do things the way they are done by the Hondurans. They will keep the statistics.

c) Clinicians:

The patients will be triaged to ensure that we see the sicker patients first. The Honduran physician should be in charge of this. The common problems like backpains, headaches, colds, diarrhea should be sent to the Preventive Medicine class where the nurse or the health educator will give them the analgesic, ORS, Vitamins and also explain the cause and the way to prevent it (if video is available it will be better). Our secretaries could be trained to do this.

Each physician or PA should have a place where he/she can examine the patient. We are going to fill the Honduran form (AT-1) for the patient consultation. The Translator could fill it.

If its not unreasonable we are going to try to treat the diseases the way the Hondurans do it, according to the policy of the Ministry of Health described in the pamphlet of each program. The liaison physician at Medical Operations will translate for you the pamphlets and we will discuss the subject with the Commander and the physician of the Ministry of Public Health, in order to have a concrete treatment.

We will try to refer patients to the health center programs (growth and development, pregnancy etc.).

d) Pharmacy:

The Pharmacy should have a translator to ensure that the patient understands exactly the way to take the medication. If it is possible we can take one or two university pharmacy students.

Our stock should have medication according to the National Drug list of the Ministry of Public Health and ensure that the CESAR and CESAMO are allowed to handle the medication we leave with them.

e) Preventive Medicine Section:

This will be our main focus, they will take care of the following:

- 1) Health Education (Nutrition, Prevention of diseases).
- 2) Deworming Station.
- 3) Immunization Team. This team is going to follow the Policy of the Epidemiology division of the Ministry of Public Health. By the time the patients have their immunization we are going to explain them what is the vaccine, the importance of it, which diseases are prevented with it and some of the normal reactions to the shot (Fever, BCG scar). we are going to try to reproduce the pamphlets that the Ministry has.
- 4) Basic Sanitation:
  - 4a) We are going to try to motivate the community so they can build, with our help, latrines, waste disposable places, dig wells, etc. If it is possible we can start at the local school and involve the teacher, parents and community in order to teach the small kids the importance and needs of basic sanitation. Hopefully this kids will carry this message to their homes and along their lives.  
  
The Ministry of Public Health will provide the materials for the latrines and the pumps.
  - 4b) Water Samples. This is to reinforce the dental program studies and to try to give ideas to the community "How can they drink better water and avoid diseases".

5) Nutrition:

Basically what are going to teach them is the importance of a diet and "How to use their food source or improve it without expending a lot of money (we can use the video).

f) Dental Section:

Until now our job has been to pull teeth. While continuing that, we are also going to reinforce a preventive dentistry program designed by the Oral program of the Junta Nacional de Bienestar Social (National Board for Social Welfare).

The Honduran dentist is going to give a talk about "How to take care of your teeth", brushing techniques, the importance of it. The school teacher is going to be involved in this programs. We will leave tooth-brushes at school so everyday the teacher will reinforce and supervise the technique.

We can also run a fluoridation program at school and select those kids in the village that have damage to the first molar and try to do fillings (for this activity we can count with the help of the Dental Department of "Sanidad Militar" (Honduran General Surgeon's Office), they have two dental field chairs + generators.

With all these our program could cover the following:

- Extractions - U.S. Dentist
- Fluorination Campaign - U.S. Personnel and Honduran dental technicians.
- Fillings for the 1st molar - Honduran Dentists (1 civilian and 1 military).

g) Veterinary Section:

This section can work with the Ministry of Public Health in or rabies control program and with the Ministry of Natural Resources in the animal immunization program and health. We are going to select some villagers and working together we are going to teach them what is the importance of the vaccines, how to prevent diseases and how to detect early symptoms.

We will try to get some pamphlets to leave them at the village.

h) Agronomy Program - to show techniques of composting, crop rotation, etc.

III. THE VILLAGES - The Medical Needs

The Commander's policy will be discussed with the General Director of the Ministry of Public Health. We will ask the General Director to inform his regional Directors in their monthly meeting, if they want we can present our plan to them in their meeting.

Next step is to coordinate with the Regional Director of the region we are going to work to select the Area's CESAMOs and CESARs where they need help.

Choose an area and meet with the personnel. This can be done in the monthly meeting that the area has with all the nurses and health promoters. We can also invite the physicians. In this meeting we are going to explain our program and ask for their cooperation.

Once we have chosen a CESAMO or CESAR to work with we will ask to be present at the monthly meeting with the volunteer personnel. (Health Guardian, Midwife, Health Representative and Malaria Worker).

Schedule our recon. There will be villages that will only need immunizations and others where we can do a complete mission. We will try to find a central village to work on it and maybe the immunization team can mobilize to the satellite villages.

It is necessary to have criteria for site selection, based on:

- Inaccessibility of upgraded roads.

- Distance to the nearest health facility.
- Medical needs, population.
- Others.

It is important to keep records and statistics of all our work and to establish parameters to evaluate every mission in order to schedule follow ups and be able to see how much improvement are we getting.

Also it is important to feed the Honduran Health Statistic System with data so they can have an idea of what their needs are and try to cover them.

At the recon we should contact the health workers, school teacher, village leader and representatives of the community trying to have in every village a health group which will work closely with the CESAR, or CESAMO. These people will be in charge of describing their needs and possible solutions. if they need our help, try to make them give us an idea how can we help and what will the community counterpart will be. (arrangements at the villages, corral, landing zone, etc.).

- P.D.1) We can leave an information sheet at the village so they know what are we going to do and what we need.
- P.D.2) If we form a health group we can give them one book of "Where there is no doctor/dentist".

HELP MISSION  
RECON CHECK LIST

Village: \_\_\_\_\_

Grid: \_\_\_\_\_

Sheet #: \_\_\_\_\_

A. 1) Aldea (Name of the Village)

1a. Way to communicate: Telephone \_\_\_\_\_ Telegraph \_\_\_\_\_ Other \_\_\_\_\_

2) Health Workers:

2a. Health Guardian: \_\_\_\_\_

2b. Midwife: \_\_\_\_\_

2c. Health Representative \_\_\_\_\_

3) Other personnel available:

3a. School Teacher: \_\_\_\_\_

3b. Village Leader: \_\_\_\_\_

3c. Auxiliary Mayor: \_\_\_\_\_

3d. Fusep Delegate: \_\_\_\_\_

4) Nearest CESAR:

4a. Distance: \_\_\_\_\_

4b. Transportation Available: \_\_\_\_\_

4c. Number and type of staff: \_\_\_\_\_

4c1. Name of the nurse: \_\_\_\_\_

4c2. Name of the Health Promotor: \_\_\_\_\_

4c3. Other: \_\_\_\_\_

5) Nearest CESAMO:

5a. Distance: \_\_\_\_\_

5b. Transportation Available: \_\_\_\_\_

5c. Number and type of staff: \_\_\_\_\_

5c1. Name of the physician (Social Service) \_\_\_\_\_

5c2. Others: \_\_\_\_\_

6) Nearest Hospital \_\_\_\_\_ Distance: \_\_\_\_\_

6a. Area Hospital: \_\_\_\_\_

6b. Regional Hospital: \_\_\_\_\_

6c. National Hospital: \_\_\_\_\_

**B. Health Information:**

1) Population: \_\_\_\_\_

a) Adults: \_\_\_\_\_

b) Children: \_\_\_\_\_

c) Infants: \_\_\_\_\_

2) Number of Houses: \_\_\_\_\_

Latrines: \_\_\_\_\_

Water Pump: \_\_\_\_\_

Water Source: \_\_\_\_\_

3) Main Diseases: \_\_\_\_\_

Diarrhea: \_\_\_\_\_

Colds: \_\_\_\_\_

Skin Problems: \_\_\_\_\_

Malaria: \_\_\_\_\_

TB: \_\_\_\_\_

Others: \_\_\_\_\_

4) 5 leading causes of death:

Adults: \_\_\_\_\_

Children: \_\_\_\_\_

Infants: \_\_\_\_\_

5) Veterinary Information

5a. Number of:

I. Cattle: \_\_\_\_\_

II. Horses/Mules: \_\_\_\_\_

III. Goats: \_\_\_\_\_

IV. Pigs: \_\_\_\_\_

V. Dogs/Cats: \_\_\_\_\_

5b. Number of animals which died in the last 3 months. \_\_\_\_\_

5c. Causes or reasons of deaths: \_\_\_\_\_

6) General living conditions:

a) Clothes: \_\_\_\_\_  
shoes: \_\_\_\_\_ barefoot \_\_\_\_\_

b) Housing: \_\_\_\_\_

c) Electricity: \_\_\_\_\_

d) Stores: \_\_\_\_\_

e) Crops: \_\_\_\_\_

f) Main food sources: \_\_\_\_\_

g) Main source income: \_\_\_\_\_

7) Type of health care to be given:

C. Flight Information

1) Pilots who flew recon \_\_\_\_\_

2) Adequate Landing Zone for:

a) UH-1 #

b) UH-60 #

c) CH-47 #

D. Diagram of area for mission

D1. Draw

D2. Explain on site triage

D3. Explain patient flow

D4. Others/remarks



E. Items required to support mission: \_\_\_\_\_

F. Polaroids of significant features and people.

Recon made by: OIC/NCOIC

Physician/Nurse

Other members

Expected date of mission: \_\_\_\_\_

## **APPENDIX D**

### **APPROVED USES OF TITLE 10 HCA FUNDS**

**When funds are used for Honduran civilians, the following are authorized:**

- 1. Fuel for generators at MEDRETE sites**
- 2. Medical drugs**
- 3. Training equipment**
- 4. Jose Cecilio Del Valle Honduran outpatient clinic**
- 5. Medical Readiness Training Exercises**
- 6. Ulcer clinic conducted at JTF-B hospital for Honduran civilians**
- 7. Class VIII expendables**
- 8. Food for Honduran inpatients**
- 9. Educational materials**

**Restrictions:**

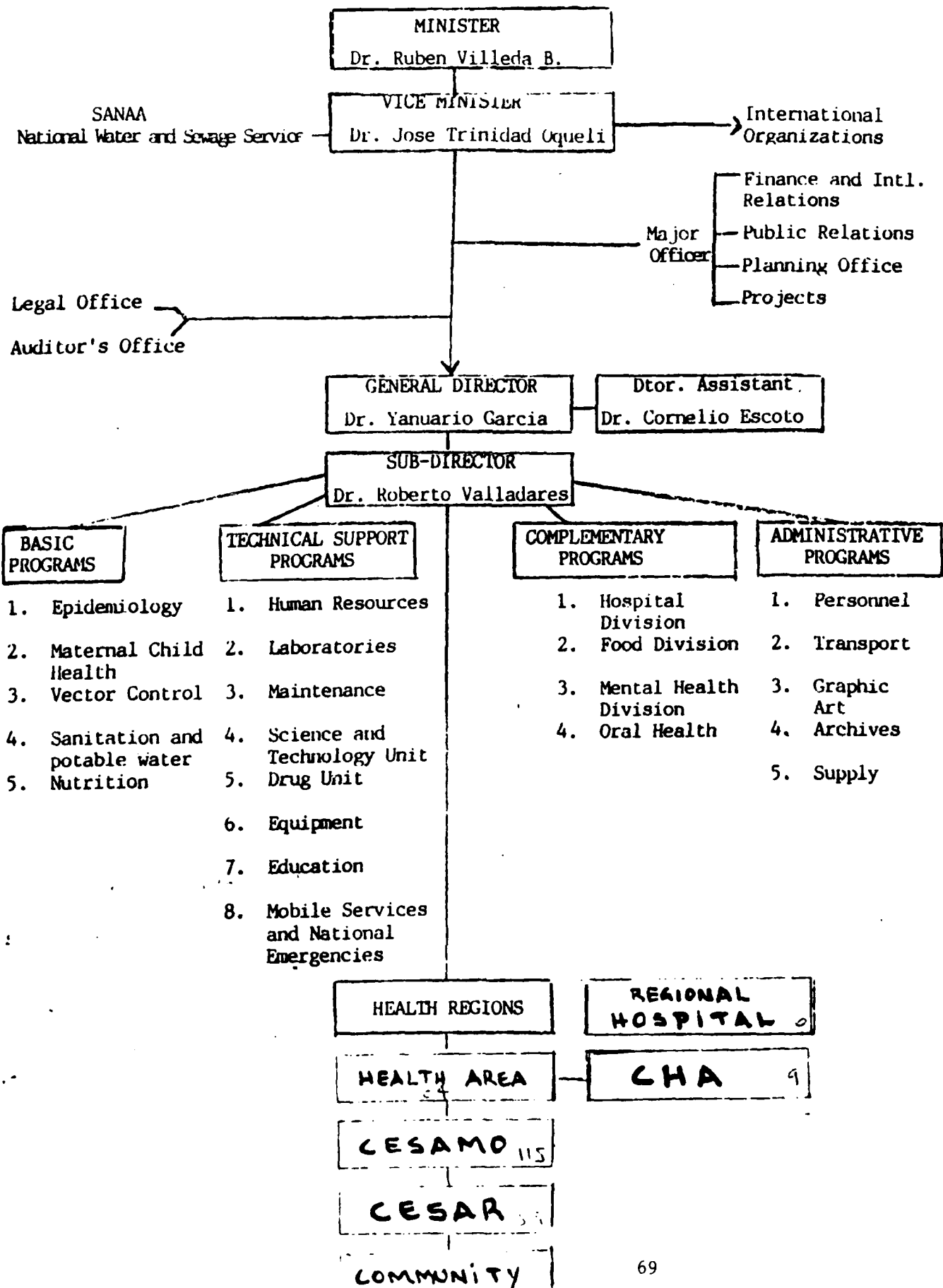
- 1. Must be used in a rural setting.**
- 2. Must be accounted for on a mission basis with skill acquisition.**

**Justification:**

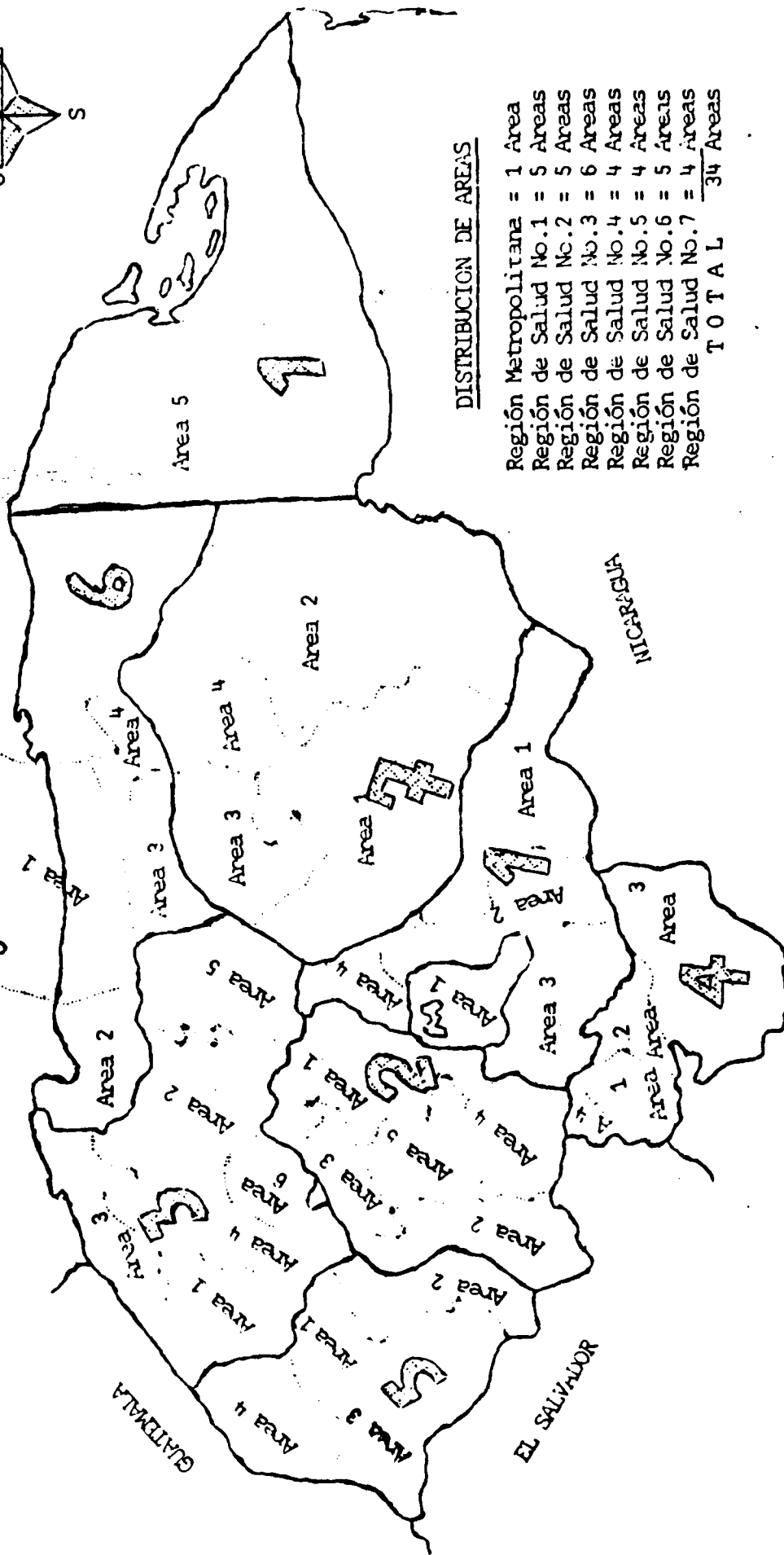
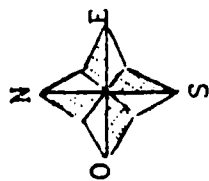
- 1. No funds are to be used for U.S. personnel.**
- 2. No funds are to be used for host nation military personnel.**
- 3. Funds are not to be used for fuel, overtime pay, or TDY.**

APPENDIX E

MINISTRY OF PUBLIC HEALTH AND SOCIAL SERVICE  
(MINISTERIO DE SALUD PUBLICA Y ASISTENCIA SOCIAL)



REPUBLICA DE HONDURAS  
REGIONES DE SALUD Y SUS AREAS  
1986



DISTRIBUCION DE AREAS

Región Metropolitana	= 1 Area
Región de Salud No.1	= 5 Areas
Región de Salud No.2	= 5 Areas
Región de Salud No.3	= 6 Areas
Región de Salud No.4	= 4 Areas
Región de Salud No.5	= 4 Areas
Región de Salud No.6	= 5 Areas
Región de Salud No.7	= 4 Areas
<b>TOTAL</b>	<b>34 Areas</b>

## HEALTH REGIONS

- |  |   |
|--|---|
| - Metrópolitan (1 área)<br>Distrito Central  | Dr. Eladio Uolés<br>Tegucigalpa             |
| - Región N° 1 (5 áreas)<br>Francisco Morazán<br>Gracias a Dios<br>El Paraíso       | Dr. Julio César Arita<br>Tegucigalpa        |
| - Región N° 2 (5 áreas)<br>Comayagua<br>La Paz<br>La Esperanza                     | Dr. Próspero Cáliz<br>Comayagua             |
| - Región N° 3 ( 6 áreas)<br>Cortés<br>Santa Bárbara<br>Part of Yoro                | Dr. Reiniery Jiménez<br>San Pedro Sula      |
| - Región N° 4 (4 áreas)<br>Choluteca<br>Valle<br>Part of Francisco Morazán         | Dr. César A. Banegas<br>Choluteca           |
| - Región N° 5 (4 áreas)<br>Ocotepeque<br>Lempira<br>Copán<br>Part of Santa Bárbara | Dr. Arnulfo Bueso P.<br>Santa Rosa de Copán |

- |                          |                  |
|--------------------------|------------------|
| - Región N° 6 (5 áreas)  | Dr. Jacobo Tábor |
| Atlántida                | La Ceiba         |
| Colón                    |                  |
| Part of Yoro and Olancho |                  |
| Bay Islands              |                  |
| <br>                     |                  |
| - Región N° 7 (4 áreas)  | Dr. Gustavo Ayes |
| Olancho                  | Juticalpa        |

NATIONAL HOSPITALS (6)

- |  |              |
|--|--------------|
| 1. Hospital General San Felipe               | Tegucigalpa  |
| 2. Instituto Nacional del Tórax              | "            |
| 3. Hospital Psiquiátrico "Dr. Mario Mendoza" | "            |
| 4. Hospital Psiquiátrico Santa Rosita        | Támara, F.M. |
| 5. Hospital Escuela Bloque Médico Quirúrgico | Tegucigalpa  |
| 6. Hospital Escuela Bloque Materno Infantil  | "            |

REGIONAL HOSPITALS (6)

- |                                     |                         |
|-------------------------------------|-------------------------|
| 1. Hospital Santa Teresa            | Reg. N° 2 Comayagua     |
| 2. Hospital "Dr. Leonardo Martínez" | " " 3 San Pedro Sula    |
| 3. Hospital del Sur                 | " " 4 Choluteca         |
| 4. Hospital de Occidente            | " " 5 Sta. Rosa d/Copán |
| 5. Hospital Atlántida               | " " 6 La Ceiba          |
| 6. Hospital San Francisco           | " " 7 Juticalpa         |

AREA HOSPITALS (9)

- |                                      |                                  |
|--------------------------------------|----------------------------------|
| 1. Hospital "Dr. Gabriela Alavarado" | Reg. N° 1 Danlí, El -<br>Paraíso |
|--------------------------------------|----------------------------------|

2. Hospital "Dr. Roberto Suazo C.	Reg. N° 2 La Paz
3. Hospital de Puerto Cortés	" " 3 Puerto Cortés
4. Hospital de El Progreso	" " 3 El Progreso, Yoro
5. Hospital Santa Bárbara	" " 3 Santa Bárbara
6. Hospital "Dr. Manuel de Jesús Su- birana	" " 3 Yoro, Yoro
7. Hospital de Tela	" " 6 Tela, Atlán- tida
8. Hospital de Tocoa	" " 6 Tocoa, Colón
9. Hospital Salvador Paredes	" " 6 Trujillo, Co- lón

#### BASIC PROGRAMS

1. P.A.I. (Programa de Inmunizaciones)  
Immunization Program (Polio, DPT, Measles, Tetanus, Toxoid,-  
BCG) .
2. Tuberculosis
3. C.E.D. (Control de Enfermedades Diarreicas)  
Control of Diarrhea (Oral Rehydration)
4. I.R.A. (Infecciones Respiratorias Agudas)  
Acute Respiratory Infections
5. Rabia  
Rabies control
6. E.T.S. (Enfermedades de Transmisión Sexual)  
S.T.D. (Sexual Transmitted Disease)
7. Saneamiento Básico  
Basic Sanitation (Latrines, Water service, Trash)

**I. Community**

1. Local or Health Committee (Comite de Salud)
2. Volunteer Personnel
  - a. Health Guardian (Guardian de Salud)
  - b. Midwife (Empirical Trained) Partera
  - c. Health Representative (Representante de Salud)
  - d. Malaria Worker

**II. CESAR: Centro de Salud Rural (Rural Health Center)**

1. Nurse Assistant (Auxiliar de Enfermeria)
2. Health Promotor
3. Malaria Worker

**III. CESAMO: Centro de Salud con Medico y Otros  
(Health Center with Physician and Others)**

1. General Physician (Social Service)
2. Nurse Assistant
3. Health Promotor
4. Malaria Worker
5. Laboratory Technician (X-ray)
6. Dentist (Social Service)

**Area CESAMO**

1. Area Chief (Physician)
2. Chief Nurse (Professional Nurse)
3. Administrator
  - a. Statistic
  - b. Warehouse

**IV. CHA: Centro Hospitalaria de Area (Area Hospital - Emergency)**

1. Surgery
2. Internal Medicine
3. Gynecology/Obstetrics
4. Pediatrics
5. Dentistry

**V. REGIONAL HOSPITALS**

1. Internal Medicine
2. Surgery
3. Gynecology/Obstetrics
4. Pediatrics
5. Orthopedic
6. Ophthalmology



7. Dentistry
8. Anesthesiology
9. X-ray
10. Otolaryngology

#### VI. NATIONAL HOSPITALS

1. Instituto Nacional del Torax (Chest Hospital)
2. Hospital Psiquiatrico Dr. Mario Mendoza
3. Hospital Psiquiatrico Santa Rosita
4. Hospital Materno Infantil
5. Hospital Escuela
6. Hospital San Felipe